

X 4041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in the presence of a licensed physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 or 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8525136	
												REG. NO.	
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			GEORGE P BAILEY						SEPT 25 85			5 15 AM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
MALE			WHITE			9 13 93			92 YRS.			IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.	
MARYLAND			USA						CARROLL			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
SYKESVILLE			SKESVILLE ELDERCARE						Ret.- Edgewood Arsenal- War Dept				
13a. STATE MARYLAND			13c. COUNTY Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2505 E. TOPPA ROAD 21234				
14. FATHER'S NAME FIRST George			MIDDLE T.P.			LAST Bailey			15. MOTHER'S MAIDEN NAME FIRST Ella			MIDDLE Cole	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
YES			WW I			220-20-7889			Mrs. Virginia B. Ford			Same as # 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.H.F.													
DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 28</u> , 1985, to <u>Sept. 25</u> , 1985, that (I) (we) lost sow the deceased olive on <u>Sept. 9</u> , 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									COUNTY STATE				
22b. SIGNATURE <i>John Doe</i>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jose L. Chaspulle, M.D.</i>			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-27-85			23c. NAME OF CEMETERY OR CREMATORIAL Parkwood			23d. LOCATION CITY OR TOWN Baltimore, Maryland			COUNTY STATE	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 27 1985			25b. REGISTRAR'S SIGNATURE <i>John Doe</i>				

11000

3

100

100

100

100

100

bifurc. corolla

brownish

white

lakun

white streaked with brownish

267027

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 5 / 3 1

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Madelyn C. Berwager						9 9 85				1248 M	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
F		Cauc.	MONTH	DAY	YEAR	77				IF UNDER 24 HRS	
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll Co. General			Seamstress			Clothing			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			21157		
MD	Carroll	Westminster	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	1913 Frizzellburg Rd.						
14. FATHER'S NAME FIRST			15. MOTHER'S MAIDEN NAME FIRST								
William G. Sullivan			Mazie J. Handley								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no na			212-01-8582			John Berwager			13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF PANCREAS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MOS.</u>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CHRONIC DIVERTICULITIS = FISTULA FORMATION</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/18 1985</u> to <u>8/19 1985</u> that (I) (we) last saw the deceased alive on <u>9/9 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Madelyn C. Sullivan</u>		22c. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>9/9/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY STATE		
Burial		9/12/85		Meadow Branch			Westminster Carroll MD				
24 FUNERAL DIRECTOR NAME		24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Robert K. Pritts, Sr., Westminster, MD					SEP 16 1985						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial. (If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.)

MEDICAL CERTIFICATION

1000000

1. *Locusta migratoria* L. 1858 25/31 10/11/1961

262079

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8525738

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the funeral home with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Charles			Graham		Bikle	09	15	85	5 <sup>00</sup> a.m.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male		Caucasian		MONTH	DAY	YEAR	80 yrs.			IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.		
D.C.		U.S.A.				Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Mt. Airy		Pleasant View Nursing Home			retired						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MD		Montgomery		Damascus				25701 Ridge Rd 872			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
		John		Bikle	Sarah						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS				
NO		214-09-2124		Mr. Charles R. Bikle, Damascus, MD. 20872							
18 CAUSE OF DEATH (Enter only one cause per line for part (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Orthostatic hypotension</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <i>hypoglycemia</i> BETWEEN ONSET AND DEATH (b) <i>Dilatery edema</i> 10 days (c) <i>Diabetes mellitus</i> 10 years.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>5/13/85</i> to <i>9/15/85</i> , to <i>9/15/85</i> , that (I) (did not) lost saw the deceased alive on <i>9/13/85</i> to <i>9/15/85</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.											
22b. SIGNATURE <i>James P. Kerr M.D.</i>		DEGREE					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/15/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JAMES P. KERR M.D.</i>		22e. ADDRESS <i>36618 Ridge Road, Damascus, MD.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Sept. 17, 1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Rose Hill Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Hagerstown, Wash., Maryland</i>		COUNTY		
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>		ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Maryland 21740</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 17 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Susan Townsend Randall</i>				

010000



263157

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" INSTEAD OF "DEATH". PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

ITEMS 18-22a 10/30/85 mtb F#608										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH					REG. NO. 25 / 39		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MARCY		MIDDLE Miller		LAST Bupp		2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH X 9	DAY 9	YEAR 1985	2b. HOUR		
1. SEX F			4. RACE Cauc.		5. DATE OF BIRTH MONTH 5 DAY 15 YEAR 46		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 39		IF UNDER 1 YR. MONTHS 0			IF UNDER 24 HRS. DAYS 0					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 9 9 1985			MONTH 5:10P DAY M					
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 307 Barnes Lane Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker			12b. KIND OF BUSINESS OR INDUSTRY home									
13a. STATE MD			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 307 Barnes Ave. 21157							
14. FATHER'S NAME FIRST Charles			MIDDLE C.		LAST Miller		15. MOTHER'S MAIDEN NAME FIRST Margaret			MIDDLE LAST Wagner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. na		17. INFORMANT Walter Bupp		ADDRESS 13e										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																	
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																	
(c) _____ DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9/9 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject found in bathtub											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			307 Barnes lane Carroll, Md.								
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE Margarita A. Korell			TITLE (SPECIFY) M. Assistant MEDICAL EXAMINER							DATE SIGNED 9/10/85							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn St. Balto. MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/12/85			23c. NAME OF CEMETERY OR CREMATORIAL Krider's Church			23d. LOCATION CITY OR TOWN Westminster			COUNTY Carroll		STATE MD			
24. FUNERAL DIRECTOR NAME 412 Washington Road Robert K. Pritts, Sr., Westminster, MD			ADDRESS			25a. DATE REC'D. BY REGISTRAR MD 9/18/85			25b. REGISTRAR'S SIGNATURE								



For more information about the  
National Endowment for Democracy, visit  
[www.endem.org](http://www.endem.org)

254126

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 25740

REG. NO.

1. DECEASED NAME <i>Mrs. Shirley H. Clark</i>			20. DATE OF DEATH <i>September 7 1985</i>	MONTH YEAR	DAY	YEAR	2b. HOUR <i>0510M</i>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH <b>May 8 1929</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b>	7. UNDER 1 YEAR <input type="checkbox"/>	DEATH DAYS HOURS MIN.	IF UNDER 24 HRS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County MD.</b>				
10. CITY OR TOWN OF DEATH <b>Westminster</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll County General Hospital</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cashier-Self</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Employed</b>				
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Westminster</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1237 Brehm Road 21157</b>			
14. FATHER'S NAME FIRST <b>Edward Poist</b>	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>Helen Poist</b>	MIDDLE	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-26-7924</b>	17. INFORMANT <b>Mr. Robert J. Clark</b>	ADDRESS <b>1237 Brehm Road Westminster Maryland 21157</b>				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of the lung</i> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 1 1985</i> to <i>Sept 7 1985</i> , that (I) (we) last saw the deceased alive on <i>Sept 7 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John S. Harshey, M.D.</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>9/7/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John S. HARSHEY M.D.</i>	22e. ADDRESS <i>8 Anchor St Westminster md. 21157</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>09-10-85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Lake View Mem. Park</b>	23d. LOCATION CITY OR TOWN <b>Sykesville</b>	23e. COUNTY <b>Carroll</b>	23f. STATE <b>Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Loring Evans Funeral Directors, Inc.</b>	25a. DATE REC'D. BY REGISTRAR <b>SEP 9 1985</b>	25b. REGISTRAR'S SIGNATURE <i>John S. Harshey</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_

Figure 10. The voltage profile

259206

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 25 / 41

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Helen</i>	MIDDLE <i></i>	LAST <i>Connor</i>	2a. DATE OF DEATH MONTH DAY YEAR	MONTH DAY YEAR	2b. HOUR
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY					
<i>Finksburg</i>	<i>2130 Carrollton Road</i>	<i>Housewife</i>	<i>Domestic</i>					
13a. STATE <i>Pennsylvania</i>			13b. COUNTY <i>Lackawanna</i>		13c. CITY OR TOWN <i>Carbondale</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>56 Green Street 99999</i>	
14. FATHER'S NAME FIRST <i>Matthew</i>	MIDDLE <i></i>	LAST <i>Zvalauskas</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Unknown</i>	MIDDLE <i></i>	LAST <i></i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>No</i> -----	16c. INFORMANT <i>Patricia Connor-Arden</i>	ADDRESS <i>2130 Carrollton Road Finksburg, Maryland</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ovarian Cancer Progressive</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION <i>NA</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL ATTACHMENT) <i>NA</i>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>NA</i> 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) <i>NA</i>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <i>NA</i>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, DEVICE, FARM, ETC.) <i>NA</i>	21f. LOCATION STREET <i>December 19, 1983</i>	CITY OR TOWN <i>75 Sept 85</i>	COUNTY <i></i>	STATE <i></i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>August 30, 1985</i> to <i>75 Sept 85</i> , that (I) (we) last saw the deceased alive on <i>August 30, 1985</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Neil B. Rosenbaum MD</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>7 Sept 85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Neil B. Rosenbaum</i>	22e. ADDRESS <i>Suite 209, 550 North Broadway</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>9-11-85</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Our Lady of Sorrows</i>	23d. LOCATION CITY OR TOWN <i>Finch Hill, Lackawanna, Pa.</i>	23e. COUNTY <i></i>	23f. STATE <i></i>			
24. FUNERAL DIRECTOR NAME <i>Marzullo Funeral Service</i>	ADDRESS <i>Reisterstown, Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>SEP 11 1985</i>						
25b. REGISTRAR'S SIGNATURE <i>Davidson-Kendall</i>								

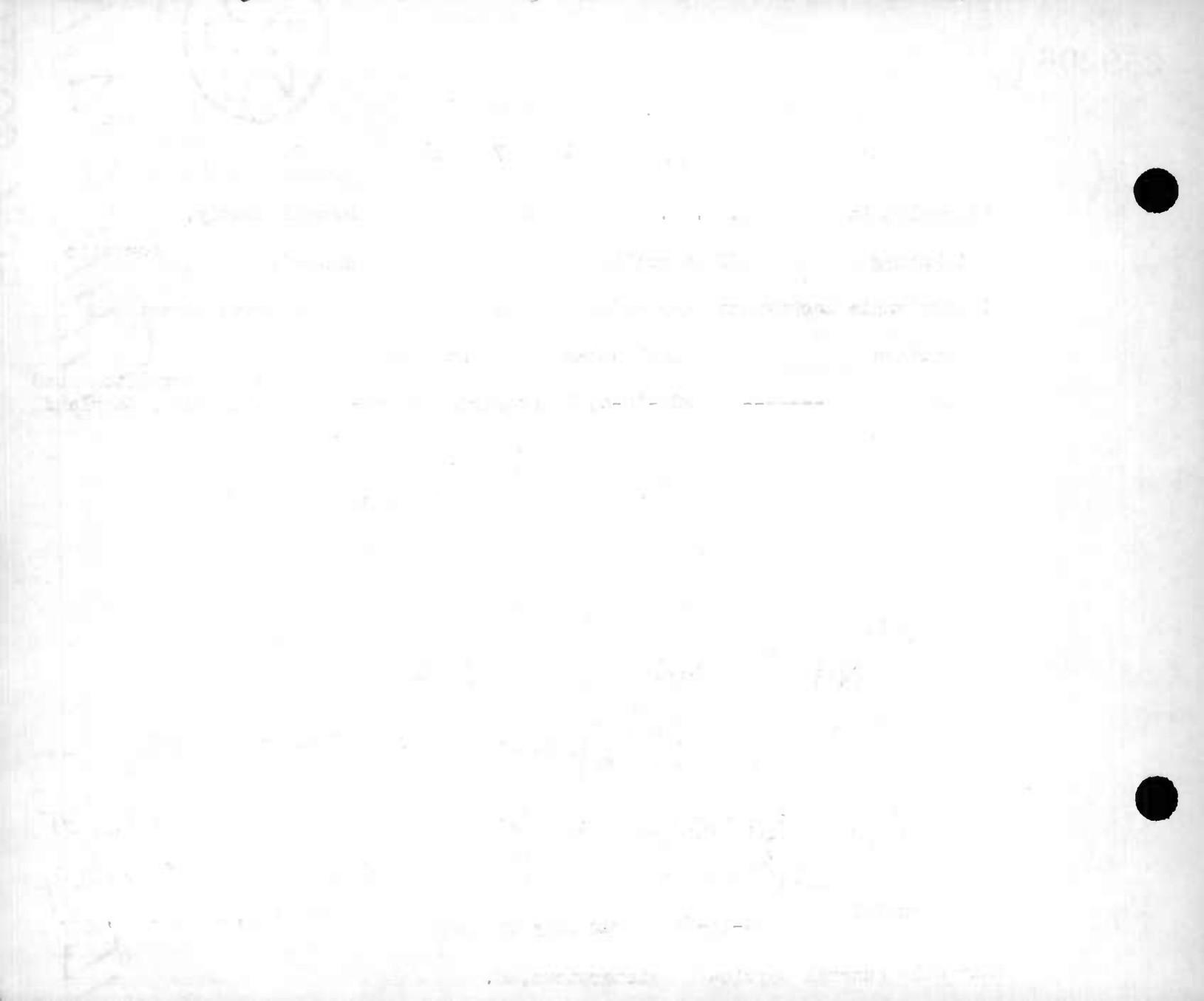
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT:

If item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately. If item 18 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

DHMH - 16 50M 4/83  
(VRA 15, 4)999999  
BP



275155

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 7 4 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ANNIE CATHERINE COOK						9-14-85				0627 M	
3. SEX		4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
FEMALE		CAUC.	MONTH	DAY	YEAR	77	IF UNDER 1 YEAR		IF UNDER 72 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA				Carroll County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll County General Hosp.			housewife			home			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
MD		Carroll	Westminster		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	350 Falcon Ct., Apt. 2D			21157		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		unknown			unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no		na		139-22-8061		2724 Bird View Rd. T. G. Cook, Jr., Westminster, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Atherosclerotic Cardiovascular disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-6-85</u> to <u>9-14-85</u> , that (I) (we) last saw the deceased alive on <u>9-13-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED <u>9/14/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHITRA CHEDU NAGANNA</u>											22e. ADDRESS <u>700 A poole Rd. Westminster</u>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>9/17/85</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Glen Haven Memorial</u>		23d. LOCATION CITY OR TOWN <u>Glen Burnie</u>		STATE <u>A.A. Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Robert K. Pritts, Sr., Westminster, MD</u>		25a. DATE REC'D. BY REGISTRAR <u>25 1985</u>		25b. REGISTRAR'S SIGNATURE <u>J. P. Pritts</u>							

editions



267015

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 25/43

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR		
MARIA C. CRAWFORD						9. 11. 85				5:35 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female		White		May 20, 1914			71 YRS			MONTHS	DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		U.S.A.					Carroll Co.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Westminster		Carroll Co. Gen. Hosp.					Housewife					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Md.		Baltimore		Owings Mills						48 Ritters Lane 21117		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS			742 Cockeys Mill Rd. Reisterstown, Md.	
Jesse		J.	Brink		Maria						3 days.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		213-82-7934		Robert Crawford								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		RESPIRATORY FAILURE										
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF EMPTY SEMA										
(b)		DUE TO, OR AS A CONSEQUENCE OF EMPTY SEMA										
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9. 7. 1985 to 9. 11. 1985, that (I) (we) last saw the deceased alive on 9. 11. 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
N. BAJPAI								9. 11. 85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
N. BAJPAI		224 Washington Hts. Westminster										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNT		
Burial		Sept. 13, 1985		Evergreen Mem. Gr.			Fin Kibung Carroll Md.					
24. FUNERAL DIRECTOR (NAME)		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
J. G. Eichhardt		Owings Mills, Md.			21117 SEP 16 1985			Juliette Johnson Pendleton				

200503

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be delivered for use as the burial-trust permit. Then please remove carbon papers. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 25 / 44

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Albert	Earl	Cropp Jr.	9	30	/ 85	1:39 P.M.		
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		
Male		White		MONTH 7	DAY 16	YEAR 1923	62			IF UNDER 21 HRS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE		
Arizona		U.S.A.		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Carroll			Post Office - Mail Man		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY				
Westminster		Carroll County Gen. Hospital		Post Office -			Mail Man				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Carroll		Hampstead		YES <input type="checkbox"/>		3790 Castle Drive 21074			
14. FATHER'S NAME		FIRST Albert	MIDDLE Earl	LAST Cropp Sr.	15. MOTHER'S MAIDEN NAME		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		10 days					
Yes		WWII		525-30-4549		Hannah M. Cropp (same as 13e)			Post mort.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ventricular fibrillation							
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b)		acute MI							
		DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).		multiple infarctions in past & COPD									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9/30/1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input type="checkbox"/> did not view the body after death.				9/19/1985		9/30/1985					
22b. SIGNATURE D. S. Kalagian		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. S. Kalagian		22e. ADDRESS 908 Washington Rd								Westminster, Md 21157	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-3-85		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l		23d. LOCATION CITY OR TOWN Arlington, Arlington, Va.					
24. FUNERAL DIRECTOR NAME John Fletcher		Thomas D. Fletcher & Son 254 East Main Street Westminster, Md. 21157		DATE REC'D. BY REGISTRAR OCT 3 1985		25b. REGISTRAR'S SIGNATURE Davidson Pendleton					

PS1023

Meeting

Enclosed

The following document was received from the Office of Economic Planning and

Trade Policy Board dated 08/08/1967. It contains the following information:

COPIES OF THE DOCUMENTS

(See page 1) ACCORDING TO THE FORM COPIES-100-100

RECORDED

276028

ITEM NUMBER 4 PER PH.CALL  
10-4-85 D.W.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH25745  
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 14 DAYS AFTER DEATH IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN ITEM 1c, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 3 RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR PAGE 3 SHOULD HE USED AS A BURIAL TRANSIT PERMIT PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS 301 W. PRESTON STREET BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Donald</i>	MIDDLE <i>Robert Cumiskey</i>	LAST <i>Cumiskey</i>	2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH 8	DAY 9	YEAR 1985	1b. TIME 1730	
3. SEX <i>m</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH 4	DAY 15	YEAR 39	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 46	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.Y.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>CARROLL</i>	
10. CITY OR TOWN OF DEATH <i>WESTMINSTER</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <i>Carroll County General Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SUPERVISOR</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>HOSPITAL</i>		
13a. STATE <i>Md.</i>		13b. COUNTY <i>BALTIMORE</i>	13c. CITY OR TOWN <i>REISTERSTOWN</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>8 FOLLY FARM COURT</i>			21136
14. FATHER'S NAME FIRST <i>WALTER</i>		MIDDLE <i>ROMULUS</i>	LAST <i>CUMISKEY</i>	15. MOTHER'S MAIDEN NAME FIRST <i>DOROTHY</i>			MIDDLE <i>ADA</i>	LAST <i>MEINHARDT</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>YES</i>		16b. SOCIAL SECURITY NO. <i>101-30-2357</i>			17. INFORMANT <i>ANN G. GUNISKEY</i>			ADDRESS <i>8 FOLLY FARM COURT REISTERSTOWN, MD.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Other Severe i/c Cardiovascular Disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		DUE TO, OR AS A CONSEQUENCE OF								
(b)		DUE TO, OR AS A CONSEQUENCE OF								
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Nature <input checked="" type="checkbox"/> causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										DATE SIGNED <i>26 Sep 85</i>
ACTUAL SIGNATURE <i>Richard Arvin Jones</i>		TITLE (SPECIFY) <i>M.D.</i> MEDICAL EXAMINER <i>Richard Arvin Jones</i>								
EXAMINER'S NAME TYPE OR PRINT)		ADDRESS <i>Carroll County General Hospital</i>								
23a. BURIAL, CREMATION, REMOVAL SPECIFY <i>CREMATION</i>		23b. DATE <i>9/28/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>SILVERBROOK Cemetery</i>			23d. LOCATION CITY OR TOWN <i>WILMINGTON</i>			23e. COUNTY <i>DEL.</i>
24. FUNERAL DIRECTOR <i>Marvin V. Wallen Jr.</i>		ADDRESS <i>CHESTERTOWN MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 30 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Juli Leiden Rodale</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or embalming.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, then the medical examiner must be notified on once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 2 5 / 4 6					
										REG. NO.					
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)				FIRST Drucilla		MIDDLE Mary	LAST Dorsey	2a. DATE OF DEATH Sept. 28, 1985	MONTH YEAR	DAY 1 am	2b. HOUR M	
3. SEX Female			4. RACE White				5. DATE OF BIRTH MONTH Dec. DAY 13, 1912 YEAR				6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Wash. D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County			MD.	
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9 Ward Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper				12b. KIND OF BUSINESS OR INDUSTRY Cemetery				
13a. STATE Md.			14b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9 Ward Ave. 21157						
14. FATHER'S NAME FIRST Leo			MIDDLE A.	LAST Bowers	15. MOTHER'S MAIDEN NAME FIRST Rosa				MIDDLE Drucilla	LAST Wahl					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-07-8631				17. INFORMANT C. Rogers Jorss				ADDRESS 9 Ward Ave., Westminster, Md. 21157				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) coronary arteriosclerosis 2/90 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE PERIOD BETWEEN DEATH AND MASTICATION scattered					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Hypertension - gross infection &															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 11/15, 1972, to 9/28, 1985, the (I) (we) last saw the deceased alive on 11/27, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED 9/30/85					
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Lew Penne R			22b. ADDRESS 3222 S Ft Davis				22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23c. NAME OF CEMETERY OR CREMATORY Oct. 1, 1985 Druid Ridge Cemetery				23d. LOCATION CITY OR TOWN Pikesville, Balto. MD.			23e. COUNTY Md.					
24. FUNERAL DIRECTOR NAME H. Echhardt			24b. DATE REC'D. BY REGISTRAR OCT 01 1985 John Tufts, Jr.				24c. REGISTRAR'S SIGNATURE John Tufts, Jr.								
DHMH - 16 50M 4/83 (VRA 15, 4)															

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1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

B 5 25747

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Everett Jackson</i>					<i>Driggers</i>	<i>9</i>	<i>17</i>	<i>PT</i>		<i>12 25 AM</i>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male		White		MONTH <i>May</i> DAY <i>3</i> , YEAR <i>1914</i>		71 YRS		MONTHS <i>0</i> DAYS <i>0</i>		HOURS <i>0</i> MIN. <i>0</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Bennettsville, S.C.		U.S.A.				Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Westminster		Carroll Co. General Hospital		Painting Contractor							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Carroll		Westminster				80 Timber Ridge Drive 21157			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
George				Driggers		Alice				Turner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		579-05-6296		Blanche H. Driggers same as #13							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Aspiration pneumonia</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Oat cell carcinoma &amp; metastasis</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>9/4</i> , 19 <i>85</i> , to <i>9-17</i> , 19 <i>85</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>9/16</i> , 19 <i>85</i> , and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <i>John W. Middleton</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/17/85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John W. Middleton</i>		22e. ADDRESS <i>182 East Main Street Westminster</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>9-19-85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Evergreen Mem. Gardens Finksburg Carroll Md.</i>		23d. LOCATION CITY OR TOWN <i>Carroll</i>		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>Thomas D. Fletcher &amp; Son</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 20 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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SEARCHED

INVESTIGATOR DIRECTOR'S OFFICE, LOS ANGELES, CALIFORNIA



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 2 5 / 4 8			
												REG. NO.			
1 - STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR			
DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		9-19-85		5 A M			
George Morrison Emerine															
1. SEX MALE				4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
						11-8-01		84		YRS					
7a. BIRTHPLACE COUNTRY MD				7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.							
10. CITY OR TOWN OF DEATH Sykesville				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1000 Johnsille Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mechanic				12b. KIND OF BUSINESS OR INDUSTRY auto					
13a. STATE MD				13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1000 Johnsille Road 21784					
FATHER'S NAME John				MIDDLE Henry		LAST Emerine		15. MOTHER'S MAIDEN NAME (unk)		LAST Lindsay					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK				16b. SOCIAL SECURITY NO. 217-16-5940		17. INFORMANT Mrs. Carolyn Shackelford		ADDRESS Sykesville, MD							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____				DUE TO, OR AS A CONSEQUENCE OF (b) _____		Cirrhosis Heart Failure 9 months									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (c) _____		Old Myocardial Infarction 4 yrs									
COPD Atherosclerosis 5.8 yrs															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
20a. MEDICAL CERTIFICATION DATE OF OPERATION				21b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from 6-25-80 to 9-19-85, that (I) (we) last saw the deceased alive on 9-10-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Kyle G. Swisher Jr.				22c. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED 9-20-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kyle G. Swisher Jr.				22e. ADDRESS 3455 Wilkins Ave - Baltimore 21225											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 9-21-85		23c. NAME OF CEMETERY OR CREMATORIALAKEVIEW CEM.		23d. LOCATION CITY OR TOWN SYKESVILLE		COUNTY CARROLL		STATE MD			
24. FUNERAL DIRECTOR NAME Harry W. Haight				ADDRESS Sykesville, MD		25a. DATE REC'D. BY REGISTRAR SEP 20 1985				25b. REGISTRAR'S SIGNATURE Harry W. Haight					

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked see Item 18

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agent MELISSA

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

35 25149

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>EAR</i>			<i>Garland</i>			<i>Sept. 5, 1985</i>				2 p.m.			
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
<i>Male</i>		<i>White</i>	<i>Aug. 28, 1926</i>			59		YRS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
<i>NC</i>		<i>U.S.A.</i>				<i>Carroll</i>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
<i>Sykesville</i>		<i>4710 Barthlow Rd.</i>			<i>Logger</i>			<i>Lumber 21184</i>					
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	ADDRESS					
<i>Md. Carroll</i>		<i>Carroll</i>	<i>Sykesville</i>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<i>4710 Barthlow Rd.</i>						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>Robert</i>		<i>Rettie</i>		<i>Byrd</i>			<i>245 24 1201</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ADDRESS					
<i>Yes</i>		<i>Viet Nam</i>				<i>Carole aust</i>							
19. MEDICAL CERTIFICATION		20. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)								
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug. 28, 1985</i> to <i>Aug. 19, 1985</i> . that (I) (we) last saw the deceased alive on <i>Aug. 28, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>B. J.</i>					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>Sept. 11, 1985</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
<i>Kusay Barakat, M.D.</i>		<i>335 Park Avenue, Frederick</i>											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN COUNTY STATE		25a. DATE REC'D. BY REGISTRAR					
<i>Burial</i>		<i>9-9-85</i>		<i>Witson Cemetery</i>		<i>Bakerville, Mitchell, N.C.</i>		<i>SEP 11 1985</i>					
24. FUNERAL DIRECTOR NAME		ADDRESS						25b. REGISTRAR'S SIGNATURE <i>G. L. Dawson - Pendle</i>					
<i>Kerry W. Haight</i>		<i>Sykesville, Md.</i>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper from bond 2 and file within 72 hours of death. IMPORTANT: If item 18 is marked or item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified on death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (including the affidavit), page 2 should be detached for use as the burial permit stamp. Then please remove carbon copy. Page 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

275039

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 25 / 50

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<i>Hazel M Goodwin</i>						<i>Sept 25, 1985</i>				<i>1720M</i>	
3. SEX		4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS	
<i>Female</i>		<i>White</i>	MONTH	DAY	YEAR	<i>80</i>	MONTHS	YEARS	MONTHS	YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
<i>Westminster</i>		<i>Carroll</i>			<i>8</i>	<i>26</i>	<i>05</i>	<i>Carroll</i>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>Westminster</i>		<i>Carroll Co Hospital</i>			<i>Shoe Factory</i>						
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
<i>Md</i>		<i>Carroll</i>	<i>Westminster</i>				<i>525 S. Frizzellburg Rd. 21157</i>				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
<i>Oscar</i>			<i>Doris</i>	<i>Annie</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
<i>No</i>		<i>214-16-1493</i>			<i>Bernard R. Blackstone</i>			<i>7332 Garfield Rd. Sykesville Md. 21184</i>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>CVA</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral atherosclerosis</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Interventor arterycardia recent. Diabetes mellitus</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN	21h. COUNTY	21i. STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 25, 1985</i> , to <i>Sept 25, 1985</i> , that (I) (we) last saw the deceased alive on <i>Sept 25, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											22k. DATE SIGNED
<i>J. M. S. Harshley, MD</i>											<i>9/25/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						
<i>John S. Harshley, MD</i>		<i>8 Avenue St. Westminster Md. 21157</i>									
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE			
<i>Burial</i>		<i>9-28-85</i>	<i>Christiansburg Crematory</i>			<i>Chesapeake</i>	<i>Carroll</i>	<i>Md.</i>			
24. FUNERAL DIRECTOR (NAME)		ADORN			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
<i>Fletcher Funeral Home</i>		<i>Westminster Md.</i>			<i>SEP 30 1985</i>			<i>Julie Davidson Pendell</i>			

ecosys



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. If you have any questions, call the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the deceased.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	5	25	75
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
VIRGIE Vida GOTTL						09 29 85						2:35 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE		CAUCASIAN		September 13 85		100			MONTHS	DAYS	HOURS	YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		9. BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		CARROLL County MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
WESTMINSTER		WESTMINSTER NURSING CONV CENTER		Housekeeper- Lord Balto. Hotel											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE						
MARYLAND		Carroll		Eldersburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			6117 Oakland Mill Road 21784						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
VIRGIL				BOWEN		BERTH.			Bowen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Iva Gardner			ADDRESS						
No				216-10-2336		3801 Schnaper Drive Randallstown, MD. 21133									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR 10 YEARS												2 DAYS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 29 85</u> , 19 <u>85</u> , to <u>Sept 29 85</u> , 19 <u>85</u> , that (we) last saw the deceased alive on <u>Sept 29 85</u> , 19 <u>85</u> , and that in (my) ( <input checked="" type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <input checked="" type="checkbox"/> ) did not view the body after death.															
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
DANIEL J. WELLIVER M.D.										9/29/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ADDRESS		218 WASHINGTON HEIGHT, WESTMINSTER MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY					
Burial		10-02-85		Woodlawn Cemetery			Woodlawn			Baltimore Maryland					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Loring Byers Funeral Directors, Inc.							OCT 1 1985								
8728 Liberty Road Randallstown, MD. 21133															



283044

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 25 / 52

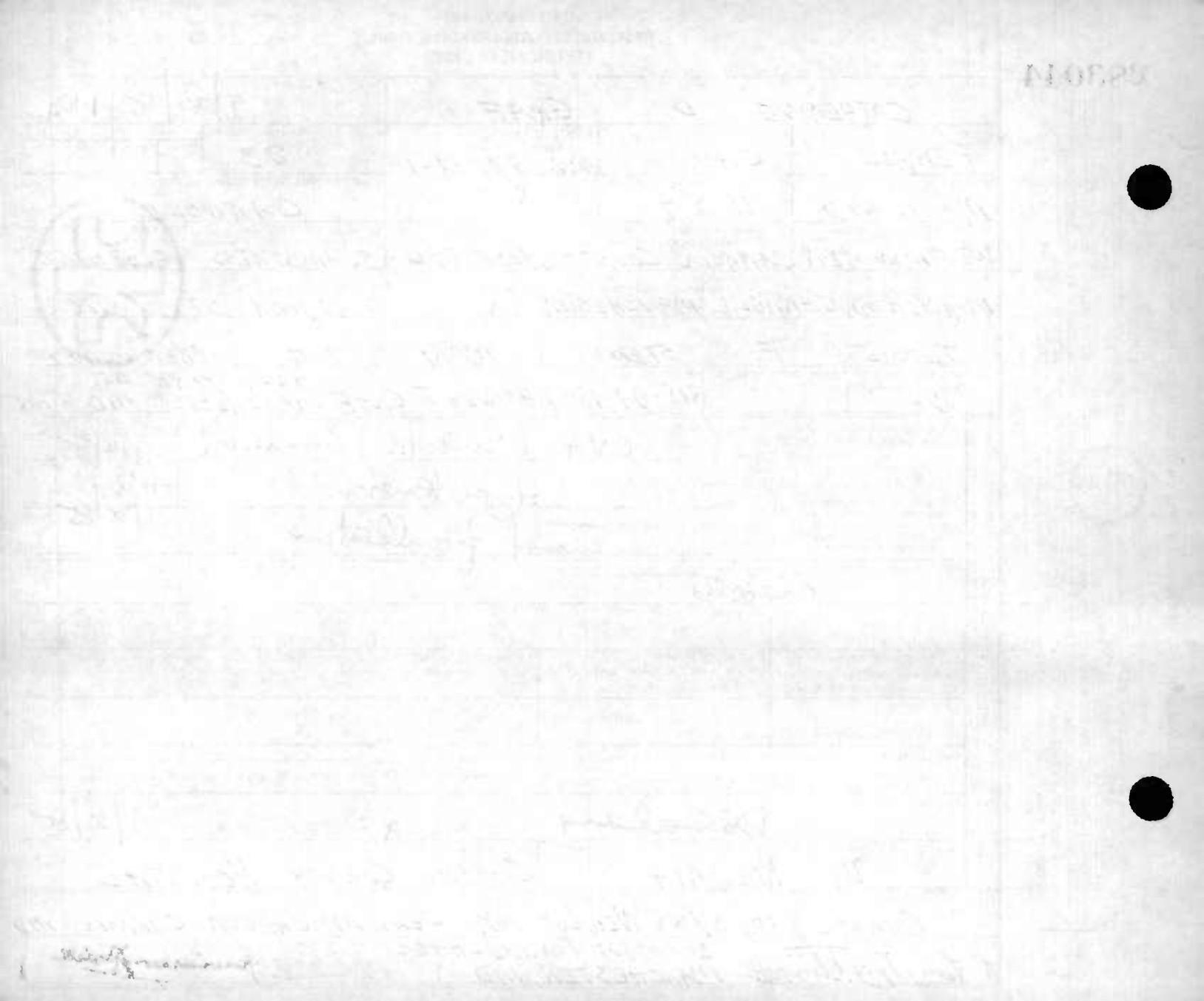
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR				
CATHERINE B. GRAF			9	30	85	1:10 A.M.				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)							
FEMALE	CAS.	NOV. 28, 1901	83 yrs.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
MARYLAND		U.S.A.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
WESTMINSTER CARROLL COUNTY HOSPITAL		SEAMSTRESS				12b. KIND OF BUSINESS OR INDUSTRY CLOTHING				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE MARYLAND	13b. COUNTY CARROLL	13c. CITY OR TOWN MANCHESTER	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3251 YORK ST 21102
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
JESSIE F. STEIN		MARY A. ORENDOFF								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		815-07-1597		HARVEY J. GRAF 3251 YORK ST MANCHESTER MD 21102				9/4/85		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA (Embolic) & multiple DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) atrial fibrillation										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b: diabetes										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. Kaloria		DEGREE MD				22c. DATE SIGNED 9/30/85				
22d. PHYSICIAN'S NAME (TYPE OF PRINT) Dr. KALORIA		22e. ADDRESS CARROLL COUNTY HOSPITAL								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/3/85		23c. NAME OF CEMETERY OR CREMATORIUM New Lycetheran Cem.		23d. LOCATION CITY OR TOWN MANCHESTER COUNTY CARROLL STATE MD				
24. FUNERAL DIRECTOR NAME R. Long Neuttington		ADDRESS ECKHARDT Funeral Chapel MANCHESTER, MD.		DATE REC'D. BY REGISTRAR OCT 03 1985				25. REGISTRAR'S SIGNATURE John W. Sandell		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place removal certificate papers, finger prints, and identification card, or tampon, with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5 5 25 / 5 3			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Addie Louise Greenwood						9-13-85					8:20 AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		MONTH 4	DAY 12	YEAR 99	86			MONTHS 5	DAYS 1	HOURS 	MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland		USA					Carroll								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Mt. Airy		Pleasant View Nursing Home		Housewife											
USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
Md		Carroll		Mt. Airy			NO		7603 Mathis Lane 21771						
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			LAST								
William		O.		Mary			E.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		PICKETT						
No		220-28-2882		Kenneth O. Greenwood, Frederick, Md.			6712 S. Clifton Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Metastatic oral carcinoma															
DUE TO, OR AS A CONSEQUENCE OF (b)															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Insulin Dependent Diabetic Mellitus															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (1) (this hospital) attended the deceased from 8-30 19 85 to present 19 , that (we) lost above, (1) we did not view the body after death.															
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
Ronald B. Miller MD															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
Ronald B. Miller MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-16-1985		23c. NAME OF CEMETERY OR CREMATORIAL Pine Grove			23d. LOCATION CITY OR TOWN Mt. Airy, Carroll, Md.			COUNTY		STATE			
24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP. 17 1985			25b. REGISTRAR'S SIGNATURE John Burrier, Jr.								

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 25 / 54

REG. NO.

1. DECEASED NAME (PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	21. HOUR		
			May	Louise	Greenwood	9	6	85				
2. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	# UNDER 1 YEAR			# UNDER 6 MONTHS		
Female		White	MONTH	DAY	YEAR	81	MONTHS	WEEKS	YEARS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.						Carroll MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Westminster		Carroll County General Hosp.			housewife			own home				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
Maryland		Carroll	New Windsor			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2078 Dennings Rd./21776			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Ulysses Kelly Haines					Ella							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			2082 Dennings Rd.				
NO		none			Helen Chorpennin			New Windsor, MD				
18. CAUSE OF DEATH (Enter only one cause of death for terminal and/or underlying causes)		PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a):  DUE TO, OR AS A CONSEQUENCE OF:  (b) Other Selected Cardiovascular Disease										
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.												
19. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS/CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the deceased) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.												
22b. SIGNATURE					DEGREE			22c. DATE SIGNED				
Richard A. Jones								75 Sep 85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS			Westminster, MD				
Richard A. Jones					Carroll County General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE				
Cremation		9/7/85			Carroll Cremation			Hampstead Carroll MD				
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE
D. D. Fletcher		New Windsor, Md.						SEP 11 1985				Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

230122

bennison school

18. 1. 2011

Home 2 4.1.11

email now delivered and intact. Thank you so much for your  
kind email. I will reply you tomorrow.

Best regards,

John

273011

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2 AND 3 TO THE FUNERAL DIRECTOR.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3, RETAIN PAGE 5 FOR YOUR USES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH25755  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	ISSUE NUMBER	
Roscoe Sears					Gregg	<input type="checkbox"/>	9	24	85	100	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	ISSUE NUMBER	
Male	White	6 1 14	71 yrs.			<input type="checkbox"/>	9	25	85	100	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Carroll					
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll County General Hosp.			farmer-butcher			agriculture			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		14. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS				
Maryland		Frederick		Union Bridge		<input checked="" type="checkbox"/>	11925 Houck Rd./21791				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST	MIDDLE		LAST		
A.		P.		Gregg		Minnie			Sears		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17. SOCIAL SECURITY NO.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  Conditions, if any, which gave rise to immediate cause (o) stating the under- lying cause lost.		17. INFORMANT Charles Gregg					ADDRESS 837 Rampart Way Union Bridge, MD
(b)  DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(c)  DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Richard H. Jones EXAMINER'S NAME (TYPE OR PRINT)											
TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER ADDRESS Carroll County General Hosp.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Union Cemetery			23d. LOCATION CITY OR TOWN near Union Bridge						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 26 1985						
D. D. Hartzer		Union Bridge, Md.			25b. REGISTRAR'S SIGNATURE						

BP \_\_\_\_\_  
DHMH 17  
(VR A15 ME(5))  
15M7/77

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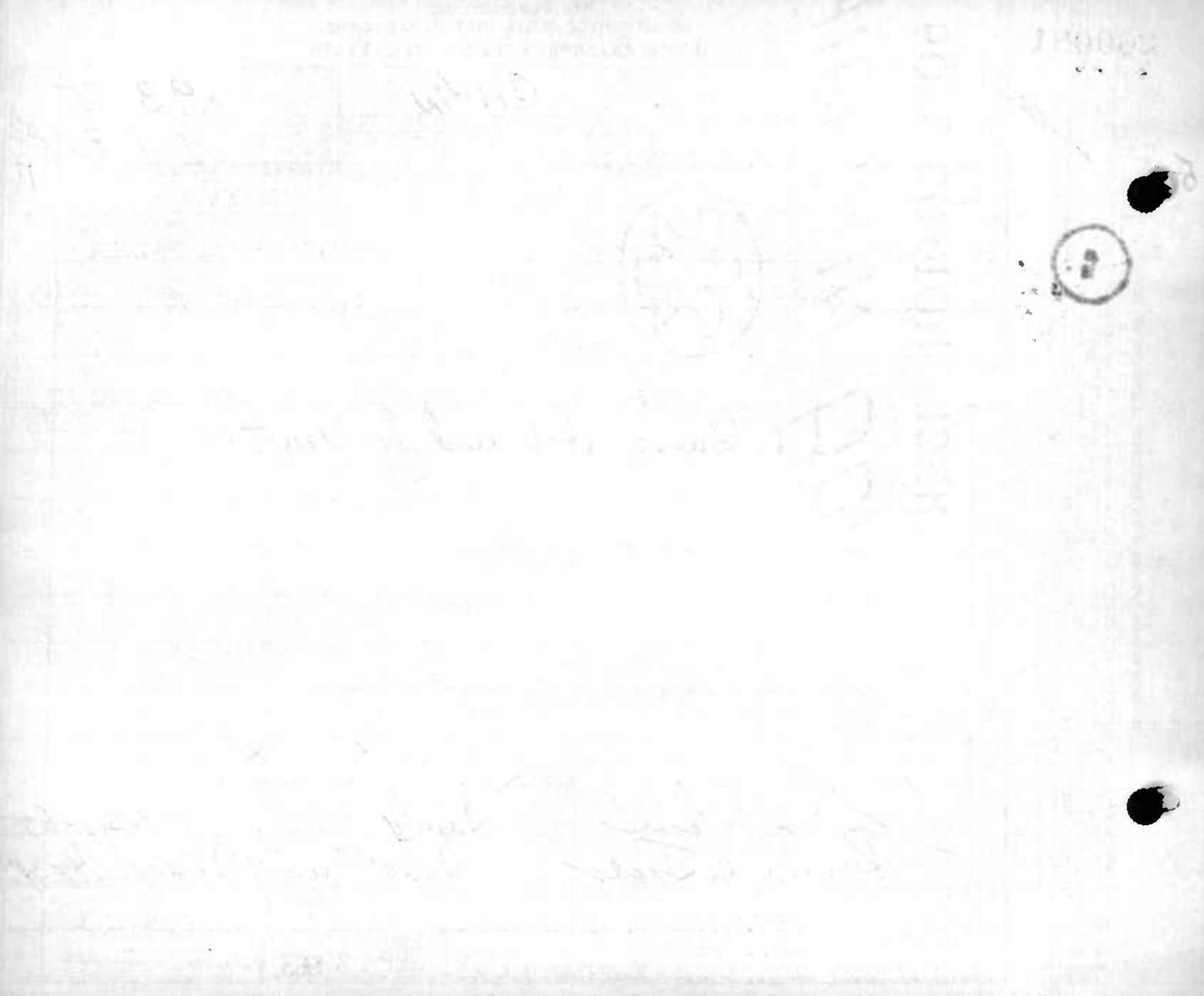
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. AND 2. TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. ITEM 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 4. ITEM 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. ITEM 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25756

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR OF ESTI- MATED <b>93 85</b>	
1. DECEASED NAME (TYPE OR PRINT)		1. FIRST JOHN S. 1. LAST <i>Griffin</i>	
2. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC 3 1946</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>38 yrs.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CALIFORNIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL</b>	
10. CITY OR TOWN OF DEATH <b>NEW WINDSOR</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NEW WINDSOR ROAD</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>QUALITY CONTROL ENGINEER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>M.D.</b>	
13a. STATE <b>MARYLAND</b>		13c. COUNTY <b>FREDERICK</b>	
14. FATHER'S NAME FIRST <b>JEROME</b> MIDDLE <b>G.</b> LAST <b>GRIFFIN</b>		15. MOTHER'S MAIDEN NAME FIRST <b>KATHLEEN</b> MIDDLE <b>CHRISTIAN</b> LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>217-44-8527</b>	
17. INFORMANT <b>MARTHA GAIL GRIFFIN WIFE</b>		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SAME AS 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gun shot wound to mouth</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b) DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET		CITY OR TOWN	
21g. COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Richard J. Stover</i>		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER ADDRESS <i>Carroll County General Hosp</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>SEPT. 7, 1985</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>MT. OLIVET CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>FREDERICK</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1985</b>	
25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randall</i>			
DHMH - 17 (VRA15 ME(5)) 15M 2/80			



276003

1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 5 25 / 5 /

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
CHARLES WALTER HAHN						September 27, 1985			4:30a.m.						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR						
Male		Caucasian		Month March 27 Year 1913		72			MONTHS DAYS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U.S.A.				Carroll Co.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Taneytown		3730 Harney Road		Farmer			Farming								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE						
Maryland		Carroll		Taneytown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3730 Harney Road/21787						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE			LAST				
		Charles	D.	Hahn	Martha						Fringer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS								
No		214-14-3744		Richard L. Hahn			3730 Harney Road			Taneytown, MD 21787					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. DUE TO, OR AS A CONSEQUENCE OF (b)		20. DUE TO, OR AS A CONSEQUENCE OF (c)		21. ADDITIONAL INFORMATION BETWEEN DEATH AND DEATH									
		Cardiopulmonary failure		metastatic Ca Colon		Date of death			Cause of death						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-26-1985 to 9-27-1985, that (I) (we) last saw the deceased alive on 9-26-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE ALBERT MCARDLE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-27-85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT MCARDLE		22e. ADDRESS GETTYSBURG 10080													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sep. 30, 1985		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Trinity Lutheran Cem. Taneytown, MD 21787		23d. LOCATION CITY OR TOWN Taneytown, Carroll, Maryland			COUNTY			STATE			
24. FUNERAL DIRECTOR NAME Skiles Funeral Home		136 E. Baltimore St.		25a. DATE REC'D. BY REGISTRAR OCT 01 1985		25b. REGISTRAR'S SIGNATURE John Skiles									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from pages 1 and 2. Should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified and



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the State Dept. of Health and Mental Hygiene, it may be used in the funeral director's office and within 72 hours of death.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be affixed or sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

BP 1327

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 5 25158		
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			MARY LEWIN WETHERED			HANDWERK			SEPTEMBER 14, 1985			11:39pm		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS		
FEMALE			WHITE			APRIL 19 1927			58			MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
MARYLAND			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			CARROLL COUNTY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
SYKESVILLE			1514 ARRINGTON ROAD			TEACHER			EDUCATION					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN SYKESVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1514 ARRINGTON ROAD 21784					
14. FATHER'S NAME FIRST JAMES MIDDLE BOOKER LAST CLARK, JR.			15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE LEWINA LAST OWINGS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214/30/3851			17. INFORMANT MARK H. HANDWERK			18. ADDRESS 1514 ARRINGTON ROAD SYKESVILLE, MD 21784					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) MELANOMA WITH METASTASIS			DUE TO, OR AS A CONSEQUENCE OF (c) MELANOMA LEFT EAR LOBE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Four minutes			New 10		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												10		
19a. DATE OF OPERATION April 1984			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED X RESECTION OF MELANOMA			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 19, 1985</u> to <u>Sept 14, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE William L. Fearing MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-16-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM L. FEARING			22e. ADDRESS 3025 Belair Rd, Balt 21213											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 17 SEPT 85			23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY			23d. LOCATION CITY OR TOWN ELLIOTT CITY			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME			ADDRESS ELLIOTT CITY, MD 21043			25a. DATE REC'D. BY REGISTRAR SEP 18 1985			25b. REGISTRAR'S SIGNATURE Johnson-Fendall					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

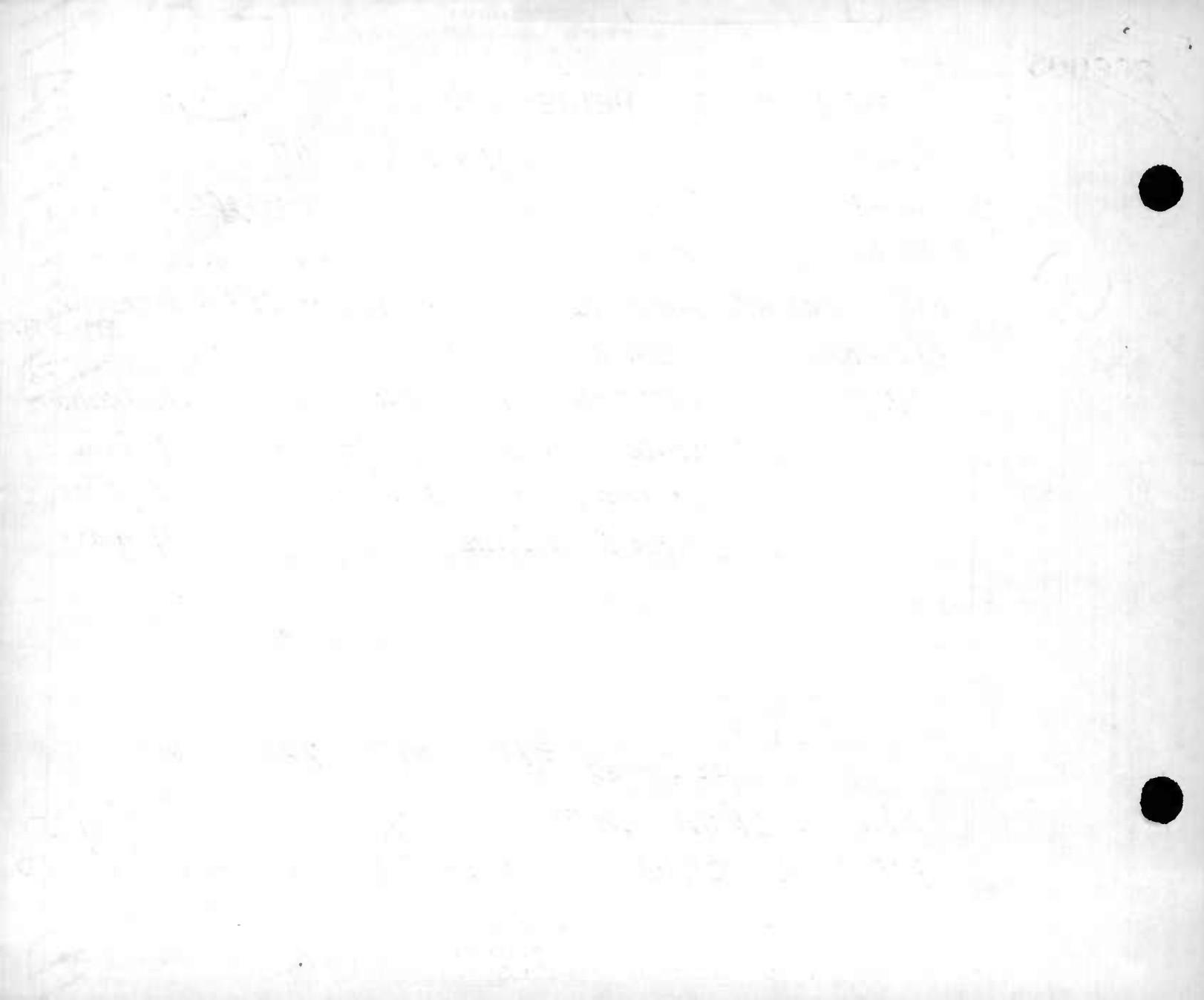
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, it should be detached from the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5 25759		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR		
EULALIA T. HEINEKAMP						9/16/85						12:00 noon		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			Caucasian		9/19/1907		77			YEARS	MONTHS	DAYS	HOURS	MIN.
7e. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			carroll county				
Pennsylvania			U.S.A.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Sykesville			2404 Haight Ave.		Ret-self-employed		New Fairview							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												Beach		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			2404 Haight Ave. Sykesville MD 21784			
MD		carroll		Sykesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			Goulden					
Clarence					Smith	Valeria								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				4202 Deep Park Rd		
NO			213-60-3711		(Son) William Heiniekamp, Randallstown									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) acute Myocardial infarction												1 hour		
DUE TO, OR AS A CONSEQUENCE OF (b) coronary heart disease												3 years		
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus												4 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
			P.M. 19											
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on			3/10 1977		to		7/23 1985		1985					
above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
Augustin Chyu, M.D.							9/19/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
AUGUSTIN CHYU.			1948 Liberty Rd. Sykesville MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial			9-20-85		Lake View Memorial Pk		Eldersburg Carroll MD							
24 FUNERAL DIRECTOR NAME			ADDRESS		Loring Byers Funeral Directors, Inc.		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
8728 Liberty Rd. Randallstown, MD 21133							SEP 19 1985			Greta Dawson-Randall				

266005



259111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5 25 / 60				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
ZIDA			V	HEPBURN		1	26	05	9	8	85	505	M			
3. SEX			RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.				
FEMALE			Caucasian	MONTH	DAY	YEAR	80	YRS.	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
VIRGINIA			U.S.A.						CARROLL COUNTY							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
MT. AIRY			PLEASANT VIEW NS6 HOME			HOUSEWIFE			21701							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
MARYLAND			FREDERICK			FREDERICK						800 MOTTER AVENUE				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS						
Edward			White		Ada					Ornoff						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
NO			820 03-9990			Audrey Smith			Virginia Beach, Va. 23452							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>Carcinomatous 2nd Bowel cancer and lung metastases</i>																
DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/1/85</u> to <u>9/8/85</u> , that (I/we) last saw the deceased alive on <u>9/15</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated (above, (we) (did) (did not) view the body after death.)																
22b. SIGNATURE <i>Melvin J. Kordemsky</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9/16/85</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Melvin J. Kordemsky</i>			22e. ADDRESS <i>2000 Century Plaza Condo</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 9-12-85			23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION CITY OR TOWN Inc. Dunkirk Calvert Md.							
24. FUNERAL DIRECTOR NAME G. Douglas Stauffer 1621 Opossumtown Pk. Fred. Md. 21701									25a. DATE REC'D. BY REGISTRAR SEP 11 1985			25b. REGISTRAR'S SIGNATURE <i>W. Henderson Pendleton</i>				

520711

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be deposited as the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

260108X

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 85 2516

1. DECEASED NAME (TYPE OR PRINT)			FIRST RUBY	MIDDLE M	LAST JACKSON	2a. DATE OF DEATH	MONTH 9	DAY 8	YEAR 85	2b. HOUR 4:25 P.M.				
3. SEX FEMALE			4. RACE CAUCASIAN			5. DATE OF BIRTH MONTH 10 DAY 18 YEAR 14			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.					
10. CITY OR TOWN OF DEATH BETH AIRY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PLEASANT VIEW NURS. HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MARYLAND			13b. COUNTY Howard			13c. CITY OR TOWN COLUMBIA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 5364 SMOOTH MEADOW WAY 21044		
14. FATHER'S NAME William O Coward						15. MOTHER'S MAIDEN NAME Lilly Williams								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 412-48-5993			17. INFORMANT ADDRESS 5364 Smooth Meadow Way Columbia Md 21044								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHARGE ARREST						DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease post M.I.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN			YRS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (c) General Atherosclerosis						> 10 yrs		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		
22a. I certify that (I) (this hospital) attended the deceased from 9/3/85 to 9/8/85, 1985, to 9/8/85, 1985, that (I/we) last saw the deceased alive on 9/3/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (had) did not) view the body after death.														
22b. SIGNATURE Melvin J. Kardon M.D.						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/8/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melvin J. Kardon M.D.			22e. ADDRESS 2000 Century Plaza Columbia MD 21046											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept 12, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery			23d. LOCATION CITY OR TOWN Anderson			COUNTY Tennessee STATE		
24. FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia Rd Ellicott City			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 11 1985			25b. REGISTRAR'S SIGNATURE					

2020.6

2020.6.20



260107

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 7 6 2

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<b>ARTHUR W. KLEIN</b>						<b>9 - 11 - 85</b>	<b>SEP</b>	<b>11</b>	<b>1985</b>	<b>0045 AM</b>			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
<b>MALE</b>		<b>WHITE</b>		<b>11 - 13 - 24</b>		<b>60</b>		<b>MONTHS</b>	<b>DAYS</b>	<b>HOURS</b>	<b>MIN.</b>		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
<b>OHIO</b>		<b>USA</b>		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		<b>Carroll County</b>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
<b>WESTMINSTER</b>		<b>CARROLL COUNTY GEN. HOSPITAL</b>		<b>Fabricator</b>		<b>Industrial Heating</b>							
13a. STATE 13b. COUNTY 13c. CITY OR TOWN												21784	
<b>MD</b>		<b>CARROLL</b>		<b>SYKESVILLE</b>		<b>6152 Oakland Mill Rd.</b>							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
<b>IRA</b>		<b>W.</b>	<b>Klein</b>		<b>Anna</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
<b>NO</b>		<b>234388802</b>		<b>Betty O. Klein</b>		<b>6152 Oakland Mill Rd. Sykesville, MD 21784</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 HRS.</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>VENTRICULAR ARRHYTHMIA</b>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>ACUTE MYOCARDIAL INFARCTION - 2 WKS AGO</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>9 - 10 - 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>D. Impar</b>		DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN		22c. DATE SIGNED <b>9-11-85</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>N. IMPAR MD</b>		22e. ADDRESS <b>224 WASHINGTON HB. WESTMINSTER</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>9-13-85</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>NEW OAKLAND Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Sykesville Carroll MD</b>		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b>		ADDRESS <b>Sykesville, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 11 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Pendleton</b>							

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial; cremation; or removal.

IMPORTANT: If item 21 is marked on item 18, then any injury, or other traumatic event, the medical examiner may be called at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 / 6 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Charles R Kramer						9 23 85				0630M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 23 HRS HOURS MIN.				
Male		Caucasian		9	6	29	56	YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
PA.		U.S.A.					Carroll			MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Westminister		Carroll County General Hosp.		Minster			Church							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE		
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Keymar		Highway, Keymar, Md. 21757						13f. Francis Scott Key		
14. FATHER'S NAME FIRST: Raymond		MIDDLE: A.		LAST: Kramer		15. MOTHER'S MAIDEN NAME FIRST: Kathryn			MIDDLE:			LAST: Daubert		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 280-28-6329		17. INFORMANT Highway, Keymar, Md. 21757 Fern E. Kramer			ADDRESS 1005 Francis Scott Key			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure												7 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (b) Ca of Colon with pentoneal, liver and lung spread						2 years 10 mos.		
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 19			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (his hospital) attended the deceased from Nov 19 85 to 23 Sept 19 85, that (I) (we) last saw the deceased alive on 22 Sept 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Donald D. Coker MD		22c. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 23 Sept 85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald D. Coker MD		22e. ADDRESS 222 Washington Heights Medical Center, Westminster, Md. 21157												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 9-26-85		23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Mem. Gd. Frederick Fred. Md.			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME G. Douglas Stauffer ADDRESS 1621 Opossumtown Pike, Fred. Md. 21701		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 26 1985 John D. Coker												

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 / 6 4

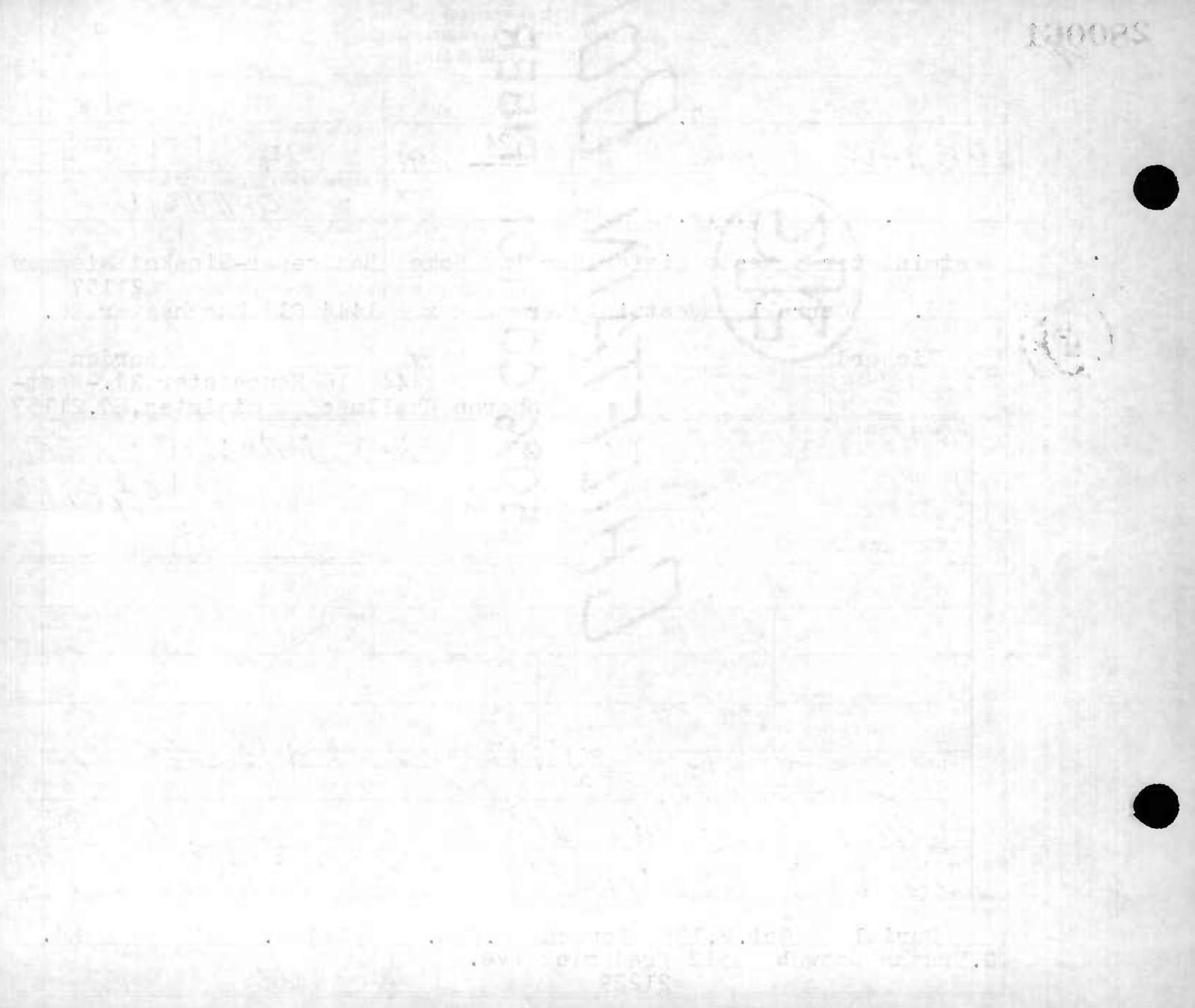
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial transit permit. Then please remove carbon paper. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as blank, it shows only injury, or other traumatic event, the medical certification section must be completed.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			JANET	G.	LAUGHLIN	09	30	85	8 10 P.M.			
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
FEMALE		CAUC	MONTH	24	YEAR	94	MONTHS	DAYS	IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.		U.S.A.						CARROLL				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Westminster		Westminster Nursing Home			Bookeeper-Giesket Nienman							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE						
						13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE	
						Md.	Carroll	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			#21157	
											1444 Old Manchester Rd.	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST			MIDDLE	LAST	
Richard				Mary							Wordon	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
(IF YES, GIVE WAR OR DATES)					1444 Old Manchester Rd.-West-							
					Sharon Challmes			Sharon Challmes				
								minister, Md. 21157				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOPATHY 8 YEARS DUE TO, OR AS A CONSEQUENCE OF (c) DISEASE												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11/12 1982 to 9/30 85, that (I) (we) last saw the deceased alive on 9/30 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE DEGREE												
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS			22e. DATE SIGNED							
DAVID J. WELLIVER M.D.		210 WASHINGTON HEIGHTS WESTMINSTER, MD.			9/30/85							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		Oct. 2, 1985		Loudon Pk. Cem.			Balto.				Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
G. Truman Schwab		3512 Frederick Ave. #21229			OCT 2 1985			Handee				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5 25 / 6 5

1. RELEASED NAME (TYPE OR PRINT)	ELSIE ELIZABETH LAWRENCE	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
2. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
F.	W.	Dec. 15, 1904	80 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll
10. CITY OR TOWN OF DEATH Union Bridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Md.	Carroll	Union Bridge	Housekeeper own home
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS
			121 N Main St. 21791
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Charles Thomas Blacksten	Josephine Virginia Poole		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
No	213-74-6732	J. Calvin Lawrence, Union Bridgex, Md. 21791	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cards/gulmors arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Min			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic CA -</i> 5 yrs			
DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN
22a. I certify that (I) this hospital attended the deceased from saw the deceased alive on above date and did not view the body after death.		21f. LOCATION CITY OR TOWN	COUNTY STATE
22b. SIGNATURE <i>J. Calvin Lawrence</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/10/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John Calvin Lawrence</i>	22e. ADDRESS 101 N Main St. UNION BRIDGE, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 1985 Sept. 14,	23c. NAME OF CEMETERY OR CREMATORIAL UNIONTOWN METHODIST	23d. LOCATION UNIONTOWN
24. FUNERAL DIRECTOR NAME <i>D. Hartzler</i>	ADDRESS New Windsor, Md	25a. DATE REC'D. BY REGISTRAR SEP 13 1985	25b. REGISTRAR'S SIGNATURE <i>Julia Dawson-Hardaker</i>

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1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

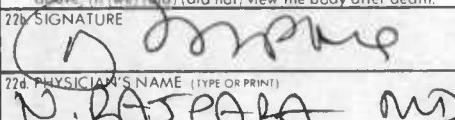
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
VEENON Dee LEADBEATER						9	23	85	21 45	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
Male		White		10 12 1934		50 YRS			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 21 HRS	
Uniontown, Pa.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Carroll			HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll County Gen. Hospital		Machinist						
13a. STATE		13b. COUNTY		14. CITY, OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Maryland		Carroll		Westminster		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		256 East Green Street 21157		
14. FATHER'S NAME		LAST		15. MOTHER'S MAIDEN NAME						
FIRST Leslie		MIDDLE Leadbeater		FIRST Loma				LAST Mae		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No		172-28-0029		Georgiana C. Leadbeater (same as 13e)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG CANCER APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.										
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. PNEUMONIA - HYPERCALCIMIA										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9 11 85 to 9 23 85, that (I) (we) last saw the deceased alive on 9 12 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE 		22c. DEGREE 		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 9.23.85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. RASPA MD		22e. ADDRESS 224 WASHINGTON HD. WESTMINSTER								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9-27-1985		23c. NAME OF CEMETERY OR CREMATORIAL Bart's U.M. Church		23d. LOCATION CITY OR TOWN Littlestown		COUNTY STATE Adams Pa.		
Burial		9-27-1985		Bart's U.M. Church		Littlestown		Adams Pa.		
24. FUNERAL DIRECTOR NAME 		25. ADDRESS 254 East Main Street Westminster, Md. 21157		26. DATE REC'D. BY REGISTRAR SEP 30 1985		25b. REGISTRAR'S SIGNATURE Julia Dawson-Kendall				

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## STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

5 25161

REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/transit, or removal.

IMPORTANT: If item 21 is marked or item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

1- STATE REGISTRAR		Eudora	Agnes Leiby	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR		
1. DECEASED NAME FIRST MIDDLE LAST		EUDORA AGNES LEIBY			SEPT 28 1985				7 40 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
FEMALE		CAUC		11 28 96		88				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		CARROLL MD.		
VA Taughannock		U.S.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
WESTMINSTER		CARROLL LUT. VILLAGE		House Mother/Mt. Rose School						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
MD		Carroll		Westminster		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1604 Bollinger Rd. 21157		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
John Clark		Mary Agnes Parker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
no		na		Kenneth Leiby, 1563 Bollinger Rd.		Westminster MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE VASCULAR INSUFFICIENCY 3 HOURS										
DUE TO, OR AS A CONSEQUENCE OF (b) ANTERIOSCLEROTIC CARDIOVASC DIS 5 YEARS										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>Sept 28 1985</u> to <u>Sept 28 1985</u> , that (I) (did) (did not) lose the deceased alive above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 9/28/85										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED						
DANIEL J. WELLIVEN		210 WASHINGTON HEIGHTS WESTMINSTER MD		9/28/85						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10/1/85		23c. NAME OF CEMETERY OR CREMATORIALoudon Park Cem.		23d. LOCATION CITY OR TOWN Baltimore County Balt. MD STATE MD				
Burial										
24. FUNERAL DIRECTOR		412 Washington Rd.		25a. DATE REC'D. BY REGISTRAR OCT 02 1985		25b. REGISTRAR'S SIGNATURE				
Robert K. Pitts, Sr., Westminster, MD										

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100. 25.52 100%

267006

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the Hospital or attending physician.

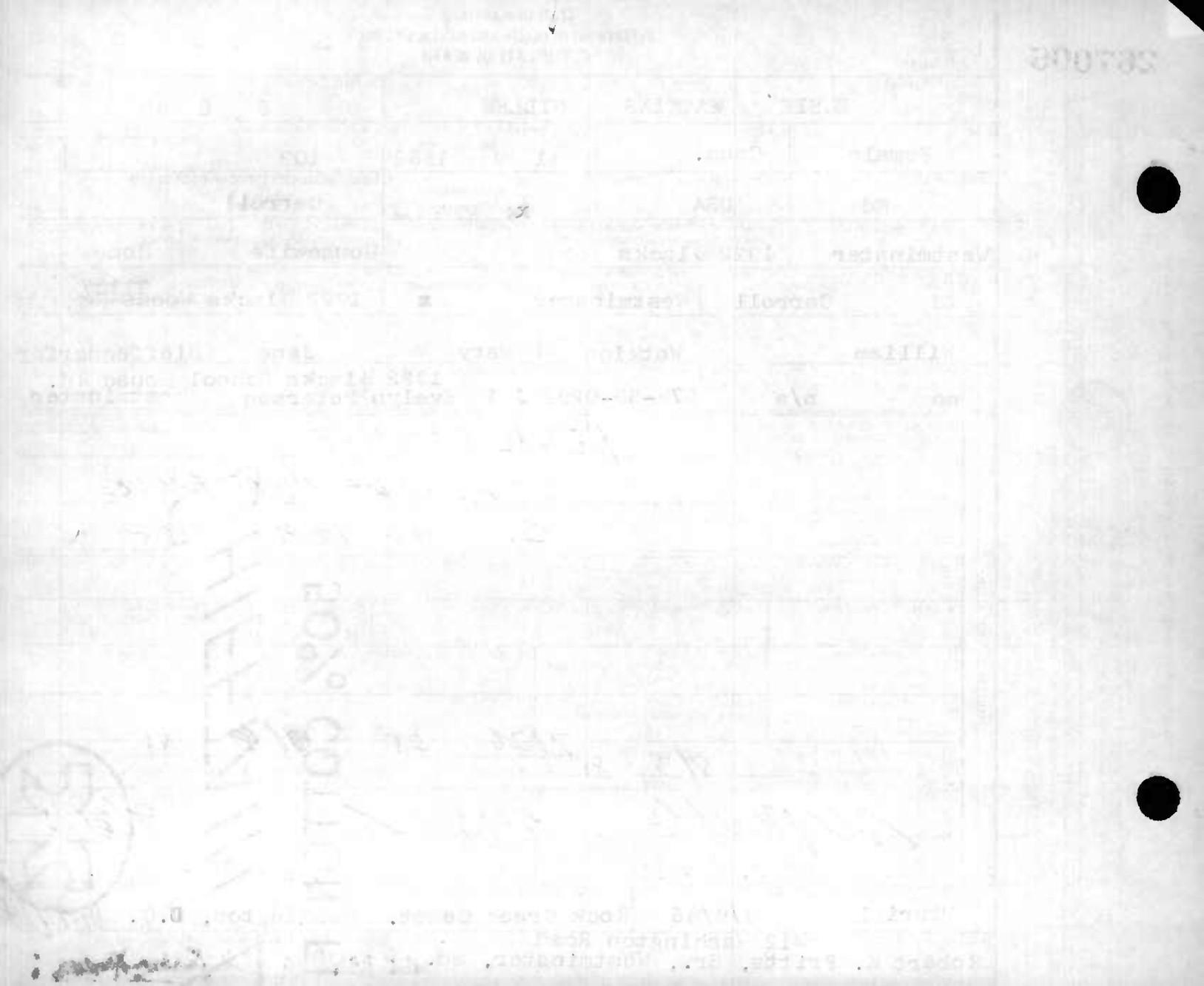
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial transit permit. Then please remove carbon paper, sign, and attach to the burial permit. This certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is modified or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 25 / 6 8			
										REG. NO.			
1. FOR STATE REGISTRAR			Film G608 item 11 10/24/85 rja										
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
ELSIE WATKINS MILLER						9 6 85						M	
3. SEX Female			4. RACE Cauc.			5. DATE OF BIRTH MONTH 11 DAY 9 YEAR 1882			6. AGE (IN YEARS LAST BIRTHDAY) 102 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE Md			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll			MD.	
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1922 Blacks School-House Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. STATE Md			13b. COUNTY Carroll			13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS School House Rd. 21157 1922 Blacks Woods Rd 21157	
14. FATHER'S NAME FIRST MIDDLE LAST William Watkins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Dieffenderfer										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a			17. INFORMANT ADDRESS J 1 Evelyn Peterson							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b>													
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY HEART DISEASE</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>7/26/85</b> , to <b>9/6/85</b> , that (I) (we) last saw the deceased alive on <b>8/3/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>M. Sevilla</i>			DEGREE Mr.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>9/6/85</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 611 Nursery Rd. Westminster, Md. 21157										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/9/85			23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemet.			23d. LOCATION CITY OR TOWN Washington, D.C.				
24. FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., Westminster, Md.			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 16 1985 <i>J. Sevilla</i>										

28780



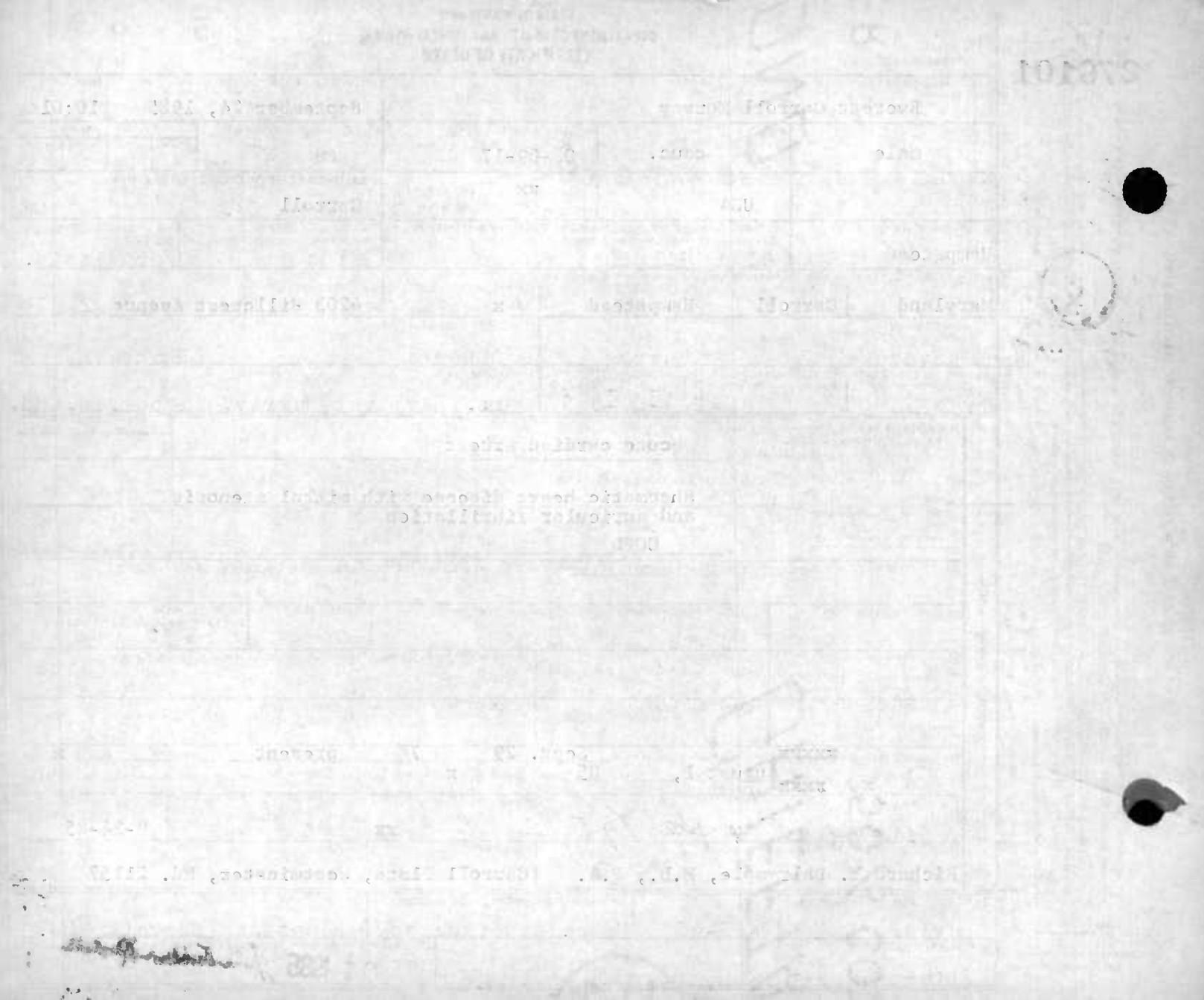
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed while the deceased is in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to the hospital or attending physician, then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 5 25 / 69
1. DECEASED NAME (TYPE OR PRINT) <b>Everett Carroll Murray</b>			2a. DATE OF DEATH <b>September 24, 1985</b>	MONTH DAY YEAR	2b. HOUR <b>10:01aM</b>	
3. SEX <b>male</b>	4 RACE <b>cauc.</b>	5. DATE OF BIRTH MONTH <b>08</b> DAY <b>09</b> YEAR <b>18</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>x68</b> 67	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co.</b>			
10. CITY OR TOWN OF DEATH <b>Hampstead</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4203 Hillcrest Avenue</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Hampstead</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4203 Hillcrest Avenue 21074</b>		
14. FATHER'S NAME FIRST <b>Everett</b>	MIDDLE <b>Murray</b>	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>Alverta</b>	MIDDLE	LAST <b>Rhoten</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	16b. SOCIAL SECURITY NO. <b>213-16-9049</b> <b>217-20-5959</b>	17. INFORMANT <b>Mrs. Margaret Murray, Hampstead, Md.</b>	ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute cardiac arrest</b>						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Rheumatic heart disease with mitral stenosis</b> and auricular fibrillation						
DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) <b>XXXXXX</b> attended the deceased from <b>Sept. 29</b> , 19 <b>76</b> , to <b>present</b> , 19 <b>85</b> , that (I) <b>(X)</b> lost saw the deceased alive on <b>August 1</b> , 19 <b>85</b> , and that in (my) <b>(X)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(X)</b> did <b>XXXXXX</b> view the body after death.						
22b. SIGNATURE <i>Richard Y. Dalrymple, M.D., P.A.</i>	DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9-24-85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard Y. Dalrymple, M.D., P.A.</b>	22e. ADDRESS <b>Carroll Plaza, Westminster, Md. 21157</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9-26-85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Hampstead Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Hampstead</b>	COUNTY <b>Carroll</b>	STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home, Hampstead, Md.</b>	ADDRESS	25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIG <b>OCT 01 1985</b>				



270035

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 25710

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		<b>JOHN HUBERT PETTIE</b>			SD. SEPT 23 1985			0200 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		MONTH	DAY	YEAR	53	IF UNDER 24 HRS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		UNITED STATES						CARROLL, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
WESTMINSTER		3605 TURKEY FOOT RD.		CARPENTER					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? NO		13e. STREET ADDRESS	
MARYLAND		CARROLL		WESTMINSTER				3605 TURKEY FOOT ROAD	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				LAST
RICHARD G. PETTIE		Sr.			Anna				Macek
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
YES		KOREA. 218-26-4099		Norma Jane Pettie (same as 13e)				12 MONTHS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG.</b>									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____									
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from DEC 19 84 to SEPT 19 85, that (we) last saw the deceased alive on SEPT 23 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Daniel I Nelliver M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-23-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL I NELLIVER M.D.</b>		22e. ADDRESS 210 WASHINGTON HEIGHTS WESTMINSTER, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-27-1985		23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn Mem. Gardens		23d. LOCATION CITY OR TOWN Marriottsville STATE Howard Md.			
24. FUNERAL DIRECTOR (NAME) <b>Dee Hob</b>		Thomas D. Fletcher & Son 14 East Main Street Westminster, Md. 21157		25a. DATE REC'D. BY REGISTRAR FAS SEP 25 1985		25b. REGISTRAR'S SIGNATURE June K. Anderson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be removed carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

26075

May 1968

CON. No.

NAME

(1) (a) (i) (ii) (iii) (iv) (v) (vi) (vii) (viii) (ix)

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267004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy page 1 and attach it to the burial permit. It should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical certification section must be filled out.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8525771	
												REG. NO.	
1 - STATE REGISTRAR				1 DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Sarah Catherine Plunkert				September 4 1985				8P.M.					
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
Female		Caucasian		10 01 1899		85 yrs							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.			
OF MARYLAND		USA						CARROLL COUNTY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Westminster		Carroll Lutheran Village		HOUSEWIFE		-							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		Westminster, MD 21157			
MD		Carroll		Westminster				53 Pennsylvania Ave.					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Henry				Willet		Jane Eliza				Study			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
UNKNOWN		219-12-0343		Laura L. Willet		1121 Stone Rd. Westminster, MD 21157							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ZOPD</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION <u>N/12</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/12</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>N/12</u> 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>N/14</u>		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/14</u>		21e. LOCATION STREET <u>N/14</u>		CITY OR TOWN COUNTY STATE			
21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NEAR WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>													
22a. I certify that <u>I</u> (this hospital) attended the deceased from <u>8</u> , 19 <u>85</u> , to <u>9</u> , 19 <u>85</u> , that <u>I</u> (we) last saw the deceased alive on <u>August 19 85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <u>I</u> (we) did (did not) view the body after death.													
22b. SIGNATURE <u>John W. Mulligan</u>		22c. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>9/5/85</u>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE <u>9-7-1985</u>		23c. NAME OF CEMETERY OR CREMATORIUM ST. MARYS CEMETERY WESTMINSTER CARROLL MD.		23d. LOCATION CITY OR TOWN COUNTY STATE							
24. FUNERAL DIRECTOR NAME <u>Robert Kyle Ruth Jr.</u>		ADDRESS <u>Westminster, Md.</u>				25a. DATE REC'D. BY REGISTRAR <u>SEP 16 1985</u>		25b. REGISTRAR'S SIGNATURE <u>John W. Mulligan</u>					
DHMH - 16 60M 7/84 (VRA 15, 4)													

100726



277059

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 5 / 7 2

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<i>Margaret E.</i>					<i>Reisberg</i>	<i>9-30-85</i>				<i>0853 M</i>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
<i>Female</i>		<i>White</i>		<i>April 23, 1917</i>		<i>68</i>		MONTH		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		7c MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		YRS.			
<i>Md.</i>		<i>USA</i>				<i>Carroll County</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
<i>Westminster</i>		<i>Carroll County Gen. Hospital</i>		<i>Homemaker</i>		<i>Home</i>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		ZIP CODE	
<i>Md</i>		<i>Carroll</i>		<i>Westminster</i>		<i>YES <input checked="" type="checkbox"/></i>		<i>5402 Marshall Drive</i>		<i>21157</i>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
<i>Nicholas</i>		<i>Elsie A. HARRY</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>No</i>		<i>213 88 6133</i>		<i>Kathleen Garver</i>		<i>Westminster, Md.</i>		<i>days</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>massive cerebro vascular</i>											
DUE TO, OR AS A CONSEQUENCE OF <i>accident &amp; right Sided weakness</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension</i> <i>years</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>diabetes mellitus - mild, abuse</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9-24</i> , 19 <i>85</i> , to <i>9-30</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>9-30</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED	
<i>Ephraim Barzaga</i>				<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<i>9-30-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
<i>Ephraim B. BARZAGA</i>		<i>NEW WINDSOR, MD. 21776</i>									
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
<i>Burial</i>		<i>10-2-85</i>		<i>St. Mary's Cemetery</i>		<i>Silver Run Carroll</i>		<i>Md.</i>			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<i>Harry W. Haight</i>		<i>Sykesville, MD</i>		<i>OCT 1 1985</i>		<i>Julie Davidson-Hendale</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove and mail to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

eaorts



276093

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 25173

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)				FIRST <u>Nannie</u>	MIDDLE <u>Minerva</u>	LAST <u>Roser</u>	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR			
				3 SEX <u>F</u>	4 RACE <u>W</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>08 22 1896</u>	6 AGE (IN YEARS LAST BIRTHDAY) <u>88</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
				7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Carroll</u>	
				10 CITY OR TOWN OF DEATH <u>Westminster</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Carroll County Gen Hospital</u>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>housewife</u>		12b KIND OF BUSINESS OR INDUSTRY <u>ownhome</u>	
				13a STATE <u>Md</u>	13b COUNTY <u>Carroll</u>	13c CITY OR TOWN <u>Keymar</u>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <u>6795 Middlebury Rd. 21757</u>			
				14 FATHER'S NAME FIRST <u>Frank</u>	MIDDLE <u>Lambert</u>	LAST <u>Maggie</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Eppley</u>				
				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>	16b SOCIAL SECURITY NO. <u>none</u>	17 INFORMANT <u>6790 Middleburg Rd. Forrest T. Roser Keymar, MD</u>					
				18 CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
				DUE TO, OR AS A CONSEQUENCE OF (b) _____							
				DUE TO, OR AS A CONSEQUENCE OF (c) _____							
				PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Pneumonia alone, Atrial Fibrillation</u>							
MEDICAL CERTIFICATION		19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
		22a. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> , 19 <u>85</u> , to <u>9/29</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/29</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
		22b. SIGNATURE <u>Norman Goldstein</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/29/85</u>			
		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Norman Goldstein</u>		22e. ADDRESS <u>718 Washington Hts Med Ctr Westminster Rd 21157</u>							
		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10/2/85</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Haugh's Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Ladiesburg</u>			
		24. FUNERAL DIRECTOR <u>D. N. Hartley</u>		ADDRESS <u>Union Bridge, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 1 1985</u>		25b. REGISTRAR'S SIGNATURE <u>D. N. Hartley</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical facility must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of page 2. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 25 / 74			
										REG. NO.			
1. FOR STATE REGISTRAR		CHARLES WILLIAM SCHEK			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE	LAST			9	15	85	P 5:10 M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male		Cauc.		MONTH 11 DAY 5 YEAR 1900			84			MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County			IF UNDER 24 HRS HOURS MIN.		
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sykesville Eldercare Center						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) C & P Telephone			12b. KIND OF BUSINESS OR INDUSTRY Teleph.		
13a. STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN Finksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2645 Sunset Lane 21048				
14. FATHER'S NAME unknown		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME Isabel			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. na			17. INFORMANT Jane M. Schek 13e								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____										DUE TO, OR AS A CONSEQUENCE OF <u>CVA - UTI</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/79, 19 85, to 9/15, 19 85, that (I) (we) last saw the deceased alive on 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22b. SIGNATURE <u>R. Ricci MD</u>		22c. ADDRESS 3125 BALT. BLVD, FINKSBURG, MD 21048						22d. DATE SIGNED 9/16/85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/16/85		23c. NAME OF CEMETERY OR CREMATORIAL Carroll Cremation			23d. LOCATION CITY OR TOWN Hamstead Carroll MD		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., Westminster, MD		25a. DATE REC'D. BY REGISTRAR SEP 27 1985			25b. REGISTRATION SIGNATURE <u>June Johnson Pritts</u>								

220023

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be surrendered within 24 hours after death. Form 3 may be retained by the hospital or attending physician.

253109

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 5 25775

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<b>NAOMI</b>			<b>B.</b>	<b>SHAEFFER</b>		<b>Sept 5, 1985</b>				<b>0040 AM</b>		
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
<b>FEMALE</b>			<b>WHITE</b>	MONTH	DAY	YEAR	83	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
<b>MIDDLEBURG, Md.</b>			<b>U. S. A.</b>						<b>CARROLL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<b>WESTMINSTER</b>			<b>CARROLL CO. GEN. HOSPITAL</b>			<b>HOUSEWIFE</b>						
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
<b>Md.</b>			<b>BALTIMORE</b>	<b>GLYNDON</b>						<b>5 WAUGH AVE. 21071</b>		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS			
<b>GEORGE</b>					<b>BARNHART</b>	<b>GRACE</b>			<b>LOWE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.			
<b>No</b>			<b>213-01-1729</b>			<b>MR. J. W. SHAEFFER</b>			<b>5 WAUGH AVE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocardial infarction</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 4, 1985</b> , to <b>Sept 5, 1985</b> , that (I) (we) last saw the deceased alive on <b>Sept 5, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John S. Harshey, md.</i>		22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED <b>9/5/85</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John S. HARSHEY, md.</i>		22e. ADDRESS <i>Pawson St. Westminster, Md. 21157</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>9-5-85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>LEISTER CEMETERY</b>		23d. LOCATION CITY OR TOWN		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME <b>ELINE FUNERAL HOME REISTERSTOWN</b>		ADDRESS <b>Md.</b>			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>SEP 6 1985</b>					
BP _____												

201628

LINE NUMBERED HOME REGISTRATION NO.  
SOUTH 2-5-82 REGISTER CEMETERY  
CARROLL  
Mr. W. M. SHAFEEER  
SOUTH 2 WANGH AVE.  
No.  
GEORGE  
Mr. BALTIMORE GRINDON  
2 WANGH AVE.  
Mr. FOWE  
BARNAHART GRACE  
SJS-01-1258 MR. J. M. SHAFEEER  
No.  
Mr. BARNABY  
WESTMINSTER CARROLL CO. GEN. HOSPITAL HOUSEWIFE  
MIDDEBURG, CO. U. S. A. X  
CARROLL COUNTY  
FENHAW  
WHITE  
SOFT RS B  
SHAFEEER  
LAWOMI

269159

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 25176												
										REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR										
ABRAHAM BERNARD SHAFER						9 16 85						1209 AM										
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS										
Male		CAUCASIAN		MONTH	DAY	YEAR	64			YEARS	MONTHS	DAYS	HOURS	MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH												
Maryland		USA					Carroll			Manchester												
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. STATE												
Long View Nursing Home				Postal Clerk			GOVERNMENT			Md.												
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
				Carroll			1201 BREHM RD. 21157															
14. FATHER'S NAME				MIDDLE	LAST	15. MOTHER'S MAREN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Abraham T.					Shaffer	Mary Elizabeth			YES				16b. SOCIAL SECURITY NO.		Ruth Ann BURGENER		0108 ELAINE DRIVE, ELLERSON, MD. 21755		10 yrs.			
16c. IMMEDIATE CAUSE (a)				16d. DUE TO, OR AS A CONSEQUENCE OF (b)			16e. DUE TO, OR AS A CONSEQUENCE OF (c)			16f. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a				16g. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a		16h. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a		16i. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a				
multiple cerebral vascular accidents				Arteriosclerosis			Arteriosclerosis			History of Hypertension + Seizure disorder				16j. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a		16k. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a		16l. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a				
17a. DATE OF OPERATION				17b. CONDITION FOR WHICH OPERATION WAS PERFORMED			17c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			17d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		18b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		18c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
19a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				19b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			19c. LOCATION STREET			CITY OR TOWN		COUNTY		STATE								
19d. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9/16 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.				19e. DEGREE			19f. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			19g. DATE SIGNED 9/16/85												
20a. SIGNATURE W.H. FOARD MD.				20b. PHYSICIAN'S NAME (TYPE OR PRINT) W.H. FOARD MD			20c. ADDRESS 3223 Main St Box E Manchester, Md 21102			20d. DATE REC'D. BY REGISTRAR OR REGISTRAR SEP 18 1985												
21a. BURIAL, CREMATION, REMOVAL Burial				21b. DATE Sept. 18, 1985			21c. NAME OF CEMETERY OR CEMETARY LEISTER'S CEMETERY			21d. LOCATION MANCHESTER, MD 21102												
22a. FUNERAL DIRECTOR Robert A. Myers				22b. ADDRESS Westminster, MD			22c. DATE REC'D. BY REGISTRAR OR REGISTRAR SEP 18 1985															



260130

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 25777

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<b>Arthur Byron Shipley</b>						9	6	85	0440 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
<b>Male</b>		<b>White</b>		<b>Jan. 3, 1901</b>		<b>84</b>		<b>8</b> <b>3</b>		<b>Hours</b> <b>Min.</b>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
<b>Maryland</b>		<b>U.S.A.</b>				<b>Carroll Co., Md.</b>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
<b>Westminster</b>		<b>Carroll Co. General Hospital</b>		<b>Farmer-Retired</b>							
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Carroll</b> 13c. CITY OR TOWN <b>Sykesville</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>21784 4615 Arthur Shipley Rd.</b>											
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
<b>Lloyd</b>		<b>Byron</b>	<b>Shipley</b>	<b>Andie</b>		<b>Jane</b>	<b>Shipley</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
<b>No</b>		<b>217-36-2609</b>		<b>Mae N. Shipley, Same As #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL ANOXIA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRONCHOPNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>WEEKS</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <b>CEREBRAL THROMBOSIS</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/23, 1985</b> , to <b>1/6, 1985</b> , that (I) (we) last saw the deceased alive on <b>9/6, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Charles W. Burrier, Jr.</i>		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>9/6/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR Crematory		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
<b>Burial</b>		<b>9-9-1985</b>		<b>Westminster</b>		<b>Westminster</b>		<b>Carroll</b>		<b>Md.</b>	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<b>Charles W. Burrier, Jr., Sykesville, Md.</b>				<b>SEP 10 1985</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate and copy of this certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper and send with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

031028

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A.P.O.

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motorization - Intensity of hours? - intensity

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on



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be reported by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified of it.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8525178

1. DECEASED NAME (TYPE OR PRINT)			FIRST Laura	MIDDLE Beatrice	LAST Simms	2a. DATE OF DEATH MONTH DAY YEAR 9-23-85	2b. HOUR 10:55 A.M.	
3. SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 06-24-1895		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS	# UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.		
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2331 Druid Hill Ave., 21217		
14. FATHER'S NAME FIRST Elijah		MIDDLE	LAST Hawkins	15. MOTHER'S MAIDEN NAME FIRST Marian		MIDDLE	LAST Snowden	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-26-3191		17. INFORMANT Springfield Hospital Center Records Sykesville, MD 21784		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 CVA								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from July 7, 1984, to September 23, 1985, that (I) (we) last saw the deceased alive on Sept. 23, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.								
22b. SIGNATURE <i>Menachem Cooper</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-23-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Menachem Cooper, M.D.		22e. ADDRESS Springfield Hosp. Ctr., Sykesville, MD 21784						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-26-85		23c. NAME OF CEMETERY OR CREMATORIAL MTR ZION Cem		23d. LOCATION CITY OR TOWN BALTIMORE CO MD		
24. FUNERAL DIRECTOR NAME JOSEPH L. RUSS		ADDRESS 2222 North Ave		25a. DATE REC'D. BY REGISTRAR SEP 25 1985		25b. REGISTRAR'S SIGNATURE <i>John J. Schaeffer</i>		
DHMH - 16 50M 4/83 (VRA 15, 4)								

130155

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 5 25779
1. DECEASED NAME: FIRST MIDDLE LAST				2. DATE OF DEATH MONTH DAY YEAR				26. HOUR				
David Victor Styers				Sept 6, 1985				10 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.		
Male		White		MONTH	DAY	YEAR	84	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
North Carolina		U.S.A.						Carroll MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										
Union Bridge		4561 Bark Hill Rd.										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
Maryland		Carroll		Union Bridge		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4561 Bark Hill Rd. / 21791				
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		16. ADDRESS				
John		Robert		Styers, Sr.		Sally		2449 Old New Windsor Pke				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		New Windsor, MD				
No		none		213-03-1056		Sally Ensor						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Progressive Dementia												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												4 yrs.
{ (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ① Parkinson's disease ② Recurrent aspiration pneumonia												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) obtained the deceased from 7/19/85, to Now, 19, that (I) (we) lost saw the deceased alive on 8/29/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED						
J.H. CARICOPE M.D.						9/06/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		
J.H. CARICOPE M.D.		P.O. Box M, Union Bridge, Md.		Burial 9/9/85		Pipe Creek Cemetery		New Windsor		Carroll MD		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
D. D. Shultz Union Bridge, Md.				SEP 11 1985		Julia Seiden Pendell						





SC9052



276020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of page 1 and 2 which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be consulted before burial.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 5 2578
1. FOR STATE REGISTRAR		1a. DECEASED NAME (TYPE OR PRINT) <b>Lillian Elizabeth Thompson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-26-85</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 11, 1908</b>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>76 YRS 11 15 0327 M</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co., MD.</b>
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminster</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>Clarence</b>		MIDDLE <b>Elmer</b>		LAST <b>Ogle</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Martha</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-42-7689</b>		17. INFORMANT <b>Fay E. Fields, 2604 Braddock Rd.</b>	ADDRESS <b>Mt. Airy, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial infarction 2 hours</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>a-20-1985</b> to <b>a-26-1985</b> , that (I) (we) last saw the deceased alive on <b>a-26-1985</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Chitrachedu Naganna</i>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9/26/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHITRACHEDU NAGANNA</b>		22e. ADDRESS <b>700A Poole Rd. Westminster MD 21157</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-29-1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Taylorsville</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Carroll, Md.</b>
24. FUNERAL DIRECTOR NAME <b>Charles W. Burrier, Jr., Sykesville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 30 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Julian K. Johnson</i>	
DHMH - 16 60M 7/84 (VRA 15, 4)					

020320

RECORDED INFORMATION

1. Name: John Doe  
2. Address: 123 Main Street, Anytown, USA  
3. Date of Birth: 10/20/1985  
4. Social Security Number: 123-45-6789  
5. Driver's License Number: 123456789  
6. Height: 5'10"  
7. Weight: 180 lbs  
8. Hair Color: Brown  
9. Eye Color: Blue  
10. Marital Status: Single  
11. Employment: Software Developer at Acme Corp.  
12. Education: Bachelor's Degree in Computer Science from University of Michigan  
13. Previous Arrests: None

14. Current Arrest: Suspected of shoplifting from a local grocery store. The victim reported seeing him in the aisle with multiple items in his pockets. He was seen leaving the store without paying for the items.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please attach certificate to body bag. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

283062

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR														
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
MIRIAM Shroyer WALLACE						9 28 85			2015 PM					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS					
Female			Cauc.			12 23 21			63					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.					
MD			USA											
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
			Carroll County General Hosp.			Teacher			School					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE MD			13b. COUNTY carroll			13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 93 W. Green St. 21157		
14. FATHER'S NAME FIRST MIDDLE LAST			Montgomery Shroyer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			Marie Noble					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
no na			578 42 4159			Charles I. Wallace 13e								
18. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>constructive pericarditis</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>radiation fibrosis</u>														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18 <u>sentopelvic carcinomatous (?) H/O breast ca</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/17, 1985, to 9/28, 1985, that (I) (we) lost saw the deceased alive on 9/28, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 9/28/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
<i>Ronald Englehardt MD</i>														
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 10/1/85			23c. NAME OF CEMETERY OR CREMATORIAL Westminster Cem.			23d. LOCATION CITY OR TOWN Westminster Carroll MD COUNTY STATE					
24. FUNERAL DIRECTOR Robert K. Pritts, Sr., Westminster, MD			412 Washington Rd.			25a. DATE REC'D. BY REGISTRAR Oct 02 1985			25b. REGISTRAR'S SIGNATURE <i>John L. Parker</i>					
DHMH - 16 60M 7/84 (VRA 15, 4)														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must make notes before certifying.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8525183		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
NORMAJEAN M. Waschler						9			13	85	12 noon	12 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Female		White		2 24 24			61			MONTHS	DAYS			
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County			IF UNDER 24 HRS				
West Virginia		USA												
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>The Westminster Nursing &amp; Convalescent Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Cashier</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Publishing</i>							
13a. STATE PA		13b. COUNTY York		13c. CITY OR TOWN New Freedom			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 34 Singer Rd. 17349				
14. FATHER'S NAME FIRST Perry		MIDDLE Hottle		15. MOTHER'S MAIDEN NAME LAST Gertrude Bohrer										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. ---		17. INFORMANT ADDRESS Jan G. Mattson, New Freedom, PA 17349										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CHF</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month.</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF														
(c) _____ DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>1982</i> , 19 <i>85</i> , to <i>1985</i> , 19 <i>85</i> , to <i>1985</i> , 19 <i>85</i> , that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22c. DATE SIGNED <i>9/13/85</i>		
22b. SIGNATURE <i>Norman Goldstein</i>		22d. DEGREE <i>B.A.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Norman Goldstein</i>		22e. ADDRESS 218 Washington Heights Hotel Westminster, MD 21157												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 15, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Greenway Cemetery			23d. LOCATION CITY OR TOWN Berkeley Springs, Morgan Co. STATE W. VA							
24. FUNERAL DIRECTOR J.J. Hartenstein, Second at Franklin St ADDRESS New Freedom, PA 17349		25a. DATE REC'D. BY REGISTRAR SEP. 18 1985			25b. REGISTRAR'S SIGNATURE <i>J. Hartenstein</i>									

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												25784 REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b HOUR
HEATHER			Nicole		WELSH	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9	4	1985	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d HOUR
Female	White	8-9-1985	27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9	4	1985	4:52 PM
9. BIRTHPLACE (STATE OR COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			
Howard County			U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Carroll County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Westminster			Carroll Co. Gen. Hospital (DOA)									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS
Maryland			Carroll			Baltimore						835 Tokala Dr. 21157
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST						LAST
Richard			James			Carrie Mae						Snead
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <input type="checkbox"/>			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
			—			Richard J. Welsh			age 35 E 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY
												STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE: 												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.												ADDRESS 111 Penn St., Balto., MD 21201
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 5-7-85			23c. NAME OF CEMETERY OR CREMATORIAL Burial Cemetery			23d. LOCATION Towson Carroll Rd.			COUNTY
24. FUNERAL DIRECTOR NAME Heather J. Fletcher & Son			ADDRESS Westmoreland			25a. DATE REC'D. BY REGISTRAR SEP 6 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall			
BP												
DHMH - 17 (VR A15 ME (5))												

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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF HEALTH AND MENTAL HYGIENE, 201 W. PRESTON STREET, BALTIMORE, MARYLAND.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 25 / 85						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR						
Leonard			Albert		Wright, Sr.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	9	2	1985								
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR						
Male	White	Oct. 28, 1942	42 yrs.	10	4	<input checked="" type="checkbox"/>			9	2	1985	8:49 p.m.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Maryland		U.S.A.						Carroll County										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY										
Westminster		Carroll County General Hospital			Machinist													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		3108 Mail Rd. (21157)								
Maryland		Carroll		Westminster		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3108 Mail Rd. (21157)										
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
		Albert	B.	Wright	Martha		Yes			1964-1966			215-40-2127			Bonnie L. Wright, Same As #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:  8152 IMMEDIATE CAUSE (a) Multiple injuries																		
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.  (b) DUE TO, OR AS A CONSEQUENCE OF																		
(c) DUE TO, OR AS A CONSEQUENCE OF																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?						
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <del>XX</del> MONTH DAY YEAR 8:49 M. 9 2 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of motorcycle lost control.												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Cardinal Dr.			CITY OR TOWN Westminster		COUNTY Carroll		STATE Md.					
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE						TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 9/3/85						
EXAMINER'S NAME (TYPE OR PRINT)			Gregory R. Kauffman, M.D.			ADDRESS 111 Penn St. Balto. MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 9-5-1985			23c. NAME OF CEMETERY OR CREMATORIAL Linganore			23d. LOCATION CITY OR TOWN Unionville, Frederick, Md.									
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP - 9 1985			25b. REGISTRAR'S SIGNATURE John Burrier									

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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, WITH FORM PAGES 1, 2, AND 3 RETAINED IN YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGES 1, 2, AND 3. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 25 / 86		
1- FOR STATE REGISTRAR			2a. DECEASED NAME FIRST MIDDLE LAST									2b. HOUR OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 9-23 1985 M		
I. DECEASED NAME (TYPE OR PRINT)			John Raymond Wroten			2c. DATE PRONOUNCED DEAD 9-23 1985			2d. HOUR MONTH DAY YEAR 2:04 p.m.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 - 12 - 42		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 47		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.								
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY WR GRACE		
13a. STATE MD			13b. COUNTY CARROLL		13c. CITY OR TOWN SYKESVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6350 Sykesville Road 21784					
14. FATHER'S NAME FIRST William MIDDLE L. LAST Wroten			15. MOTHER'S MAIDEN NAME FIRST Irene MIDDLE F. LAST Wroten											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES VIETNAM			16b. SOCIAL SECURITY NO. 219-38-8891			17. INFORMANT Jeannine D. Wroten			ADDRESS Sykesville, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-(b).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) Assistant MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.												DATE SIGNED 9-23-85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9-25-85			23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation Services			23d. LOCATION CITY OR TOWN Hamstead			COUNTY Carroll STATE MD		
24. FUNERAL DIRECTOR NAME Harry W. Haight			ADDRESS Sykesville, MD			25a. DATE REC'D. BY REGISTRAR SEP 24 1985			25b. REGISTRAR'S SIGNATURE					
BP _____		DHMH - 17 (VR A15 ME (5))												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please 4 mos 3 retron by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 5 25781		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR M		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			JOSEPH MARIA DOMINICUS ZYLSTRA								
3. SEX Male			4. RACE Cauc.			5. DATE OF BIRTH MONTH 5 DAY 20 YEAR 1897			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Netherlands			7b. CITIZEN OF WHAT COUNTRY? NETHERLANDS			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll			MD.		
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 699 Gist Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant			12b. KIND OF BUSINESS OR INDUSTRY Accounting					
13a. STATE MD			13b. COUNTY Carroll			13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 699 Gist Rd. 21157		
14. FATHER'S NAME FIRST Peter			MIDDLE Zylstra LAST			15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Maria LAST Vester								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW I			17. INFORMANT ANN LAURUSSE-B ROUWER			ADDRESS 699 Gist Rd. 21157			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 10/13/84, 19, to 9/1/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.														
22b. SIGNATURE <i>Norman Goldstein</i> DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													22c. DATE SIGNED 9/13/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman I. Goldstein			22e. ADDRESS 218 Washington Hts. Med. Center. Westminster, Md. 21157											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/16/85			23c. NAME OF CEMETERY OR CREMATORIAL St. John's			23d. LOCATION CITY OR TOWN Westminster COUNTY Carroll STATE MD					
24. FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., Westminster, MD			ADDRESS 412 Washington Road			25a. DATE REC'D. BY REGISTRAR SEP 18 1985			25b. REGISTRAR'S SIGNATURE <i>John D. Miller</i>					

